UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re: City of Detroit, Michigan, Debtor.	Bankruptcy Case No. 13-53846 Honorable Thomas J. Tucker Chapter 9

CITY OF DETROIT'S MOTION TO ENFORCE ORDER, PURSUANT TO SECTIONS 105, 501, AND 503 OF THE BANKRUPTCY CODE AND BANKRUPTCY RULES 2002 AND 3003(c), ESTABLISHING BAR DATES FOR FILING PROOFS OF CLAIM AND APPROVING FORM AND MANNER OF NOTICE THEREOF AGAINST AMERICAN ANESTHESIA ASSOCIATES, LLC AND SPINE SPECIALISTS OF MICHIGAN, P.C.

The City of Detroit, Michigan ("City") by its undersigned counsel, Miller, Canfield, Paddock and Stone, PLC, files this Motion to Enforce Order, Pursuant to Sections 105, 501, and 503 of the Bankruptcy Code and Bankruptcy Rules 2002 and 3003(c), Establishing Bar Dates for Filing of Proofs of Claim and Approving Form and Manner of Notice Thereof Against American Anesthesia Associates, LLC and Spine Specialists of Michigan, P.C. ("Motion"). In support of this Motion, the City respectfully states as follows:

I. Introduction

1. Plaintiffs, American Anesthesia Associates, LLC ("AAS") and Spine Specialists of Michigan, P.C. ("SSM"), filed separate state court lawsuits seeking a monetary award on account of a pre-petition claim against the City despite not having filed proofs of claims for the claims asserted in their respective lawsuits. In

accordance with the Bar Date Order, the City seeks an order barring and permanently enjoining AAS and SSM from asserting claims against the City or property of the City, and requiring both AAS and SSM to dismiss their respective state court lawsuits with prejudice.

II. Factual Background

A. The Bar Date Order

2. On July 18, 2013 ("Petition Date"), the City filed this chapter 9 case.

3. On November 21, 2013, this Court entered its Order, Pursuant to Sections 105, 501, and 503 of the Bankruptcy Code and Bankruptcy Rules 2002 and 3003(c), Establishing Bar Dates for Filing Proofs of Claim and Approving Form and Manner of Notice Thereof [Doc. No. 1782] ("Bar Date Order").

4. The Bar Date Order established February 21, 2014 ("General Bar Date") as the deadline for filing claims against the City. Paragraph 6 of the Bar Date Order states that the

> following entities must file a proof of claim on or before the Bar Date…any entity: (i) whose prepetition claim against the City is not listed in the List of Claims or is listed as disputed, contingent or unliquidated; and (ii) that desires to share in any distribution in this bankruptcy case and/or otherwise participate in the proceedings in this bankruptcy case associated with the confirmation of any chapter 9 plan of adjustment proposed by the City…

Bar Date Order ¶ 6.

5. Paragraph 22 of the Bar Date Order also provided that:

> Pursuant to sections 105(a) of the Bankruptcy Code and Bankruptcy Rule 3003(c)(2), **any entity that is required to file a proof of claim in this case pursuant to the Bankruptcy Code, the Bankruptcy Rules or this Order with respect to a particular claim against the City, but that fails properly to do so by the applicable Bar Date, shall be forever barred, estopped and enjoined from: (a) asserting any claim against the City or property of the City** that (i) is in an amount that exceeds the amount, if any, that is identified in the List of Claims on behalf of such entity as undisputed, noncontingent and liquidated or (ii) is of a different nature or a different classification or priority than any Scheduled Claim identified in the List of Claims on behalf of such entity (any such claim under subparagraph (a) of this paragraph being referred to herein as an "Unscheduled Claim"); (b) voting upon, or receiving distributions under any Chapter 9 Plan in this case in respect of an Unscheduled Claim; or (c) with respect to any 503(b)(9) Claim or administrative priority claim component of any Rejection Damages Claim, asserting any such priority claim against the City or property of the City.

Bar Date Order ¶ 22 (emphasis added).

6. The Bar Date Order also approved the form and manner of notice of the Bar Dates. *See e.g.* Bar Date Order ¶¶ 3, 23-26. In accordance with the Bar Date Order, notice of the General Bar Date was published in several newspapers. [Doc. Nos. 3007, 3008, 3009]. SSM received individualized notice of the Bar Date Order. Certificate of Service, Doc. No. 2337-17 at page 91 of 134. AAS also had notice of the Bar Date Order as it filed a proof of claim for services provided to a different claimant (Patricia Edwards). Claim No. 983.

7. The Bar Date Order provides that this Court retains "jurisdiction with respect to all matters arising from or related to the interpretation, implementation and/or enforcement of this Order." Bar Date Order ¶ 29.

B. The State Court Actions

8. In violation of the Bar Date Order, on July 20, 2016, SSM filed a complaint against the City ("SSM Complaint") in the Wayne County Circuit Court, Case Number 16-009119 ("SSM Lawsuit"). The SSM Complaint is attached as Exhibit 6A. SSM alleges that "[o]n or about May 23, 2013, Carrie McDonald (the "Injured Party") was involved in an automobile accident" and that on "numerous dates, Plaintiff provided medical treatment to the Injured Party for injuries they suffered as a result of the subject accident." SSM Complaint ¶¶ 5, 10. SSM seeks damages from the City due to the alleged treatment it provided to McDonald. SSM Complaint at 3.

9. In violation of the Bar Date Order, on September 21, 2015, AAS filed a complaint against the City ("AAS Complaint") in 36th District Court, Case Number 2015-119415 ("AAS Lawsuit", and together with the SSM Lawsuit, the "Lawsuits"). The AAS Complaint is attached as Exhibit 6B. The AAS Lawsuit was transferred to the Wayne County Circuit Court and assigned case number 16-008713. AAS alleges that "[o]n numerous dates, the Plaintiff provided medical treatment to Carrie McDonald, for injuries she suffered as a result of the May 23, 2012 accident." AAS Complaint ¶ 10. AAS seeks damages from the City due to the alleged treatment it provided to McDonald. AAS Complaint at 3-4.

C. Carrie McDonald's Proof of Claim and Subsequent Settlement

10. On February 19, 2014, Carrie McDonald filed proof of claim 1542 ("Proof of Claim") asserting a claim in the amount of $98,392.43. The Proof of Claim is attached as Exhibit 6C. The basis for the Proof of Claim was "PIP claim due to 5/23/12 bus crash." Proof of Claim at 1. McDonald calculated the claim amount by totaling the Medical Bills, Household Services, Wage Loss, Interest and Attorney Fees identified on page 5 to the Proof of Claim. Proof of Claim at 5. As part of the Medical Bill component, McDonald included medical bills from SSM and AAS. *Id.*

11. The City and McDonald entered into a settlement agreement with respect to the Proof of Claim ("Settlement Agreement"). The Settlement Agreement is attached as Exhibit 6D. The Settlement Agreement provides

> As to the Filed Claims and Settled Claims described herein, the Claimant releases the City from any and all liability, actions, damages and claims (including claims for attorney fees, expert fees or court costs), known or unknown, arising or accruing at any time prior to and after the date of this Agreement, that the Claimant has or may have against the City. The Claimant acknowledges that this Agreement represents the compromise of a disputed claim and is not to be construed as an admission of liability on the part of the City. As used in this Agreement, the Claimant and the City include each of their respective servants, agents, contractors, attorneys, employees, representatives, family members, heirs, elected officials, appointed officials, related corporations, subsidiaries, divisions, affiliates, directors and officers, if any.

Settlement Agreement ¶ 8.

12. Consequently, the claims asserted in the Lawsuits were released pursuant to the Settlement Agreement.

III. Argument

13. Neither AAS nor SSM filed a proof of claim in the City's bankruptcy case for the claims asserted in the Lawsuits. Consequently, pursuant to the Bar Date Order, both AAS and SSM are "forever barred, estopped and enjoined from…asserting any claim against the City or property of the City." Bar Date Order ¶ 22. As AAS and SSM's actions violate the Bar Date Order, the Lawsuits must be dismissed with prejudice.

14. Furthermore, the claims asserted in the Lawsuits were released pursuant to paragraph 8 of the Settlement Agreement. Here, McDonald released the City from "any and all liability, actions, damages and claims…known or unknown, arising or accruing at any time **prior to and after the date of this Agreement**, that the Claimant has or may have against the City." Settlement Agreement ¶ 8. Consequently, AAS and SSM cannot recover on the claims asserted in the Lawsuits because McDonald released the City from those claims. *See In re City of Detroit, Michigan*, 548 B.R. 748, 765 (Bankr. E.D. Mich. 2016) ("Thus, while the providers may bring a direct action, they are only entitled to recover whatever the accident victims themselves are entitled to recover."). For this additional reason, the Lawsuits should be dismissed with prejudice.

IV. Conclusion

15. The City thus respectfully requests that this Court enter an order, in substantially the same form as the one attached as Exhibit 1, (a) directing both SSM and AAS to dismiss, or cause to be dismissed, with prejudice their respective state court lawsuits; and (b) permanently barring, estopping and enjoining the SSM and AAAS from asserting the claim alleged in or claims related to their respective state court lawsuits against the City or property of the City. The City sought, but did not obtain, concurrence to the relief requested in the Motion.

Dated: October 6, 2016

MILLER, CANFIELD, PADDOCK AND STONE, P.L.C.

By: /s/ Marc N. Swanson
Jonathan S. Green (P33140)
Marc N. Swanson (P71149)
150 West Jefferson, Suite 2500
Detroit, Michigan 48226
Telephone: (313) 496-7591
Facsimile: (313) 496-8451
swansonm@millercanfield.com

- and -

CITY OF DETROIT LAW DEPARTMENT

Charles N. Raimi (P29746)
James Noseda (P52563)
2 Woodward Avenue, Suite 500
Detroit, Michigan 48226
Phone: (313) 237-5037
Email: raimic@detroitmi.gov

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:	Bankruptcy Case No. 13-53846
City of Detroit, Michigan,	Honorable Thomas J. Tucker
Debtor.	Chapter 9

EXHIBIT LIST

Exhibit 1	Proposed Order
Exhibit 2	Notice of Opportunity to Object
Exhibit 3	None
Exhibit 4	Certificate of Service
Exhibit 5	None
Exhibit 6A	SSM Complaint
Exhibit 6B	AAS Complaint
Exhibit 6C	Proof of Claim
Exhibit 6D	Settlement Agreement

EXHIBIT 1 – PROPOSED ORDER

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re: City of Detroit, Michigan, Debtor.	Bankruptcy Case No. 13-53846 Honorable Thomas J. Tucker Chapter 9

ORDER GRANTING CITY OF DETROIT'S MOTION TO ENFORCE ORDER, PURSUANT TO SECTIONS 105, 501, AND 503 OF THE BANKRUPTCY CODE AND BANKRUPTCY RULES 2002 AND 3003(c), ESTABLISHING BAR DATES FOR FILING PROOFS OF CLAIM AND APPROVING FORM AND MANNER OF NOTICE THEREOF AGAINST AMERICAN ANESTHESIA ASSOCIATES, LLC AND SPINE SPECIALISTS OF MICHIGAN, P.C.

This matter, having come before the Court on the Motion to Enforce Order, Pursuant to Sections 105, 501, and 503 of the Bankruptcy Code and Bankruptcy Rules 2002 and 3003(c), Establishing Bar Dates for Filing of Proofs of Claim and Approving Form and Manner of Notice Thereof Against American Anesthesia Associates, LLC and Spine Specialists of Michigan, P.C. ("Motion")[1], upon proper notice and a hearing, the Court being fully advised in the premises, and there being good cause to grant the relief requested,

[1] Capitalized terms used but not otherwise defined in this Order shall have the meanings given to them in the Motion.

THE COURT ORDERS THAT:

1. The Motion is granted.

2. Within five days of the entry of this Order, Plaintiff American Anesthesia Associates, LLC ("AAS") will dismiss, or cause to be dismissed, with prejudice its complaint filed on or about September 21, 2015 in the 36th District Court, Michigan, case number 2015-119415 and transferred to Wayne County Circuit Court, case number 16-008713 ("AAS Lawsuit").

3. Within five days of the entry of this Order, Plaintiff Spine Specialists of Michigan, P.C. ("SSM") will dismiss, or cause to be dismissed, with prejudice its complaint filed on or about July 20, 2016 in Wayne County Circuit Court, case number 16-009119 ("SSM Lawsuit").

4. AAS is permanently barred, estopped and enjoined from asserting the claim arising from or related to its AAS Lawsuit against the City of Detroit or property of the City of Detroit.

5. SSM is permanently barred, estopped and enjoined from asserting the claim arising from or related to the SSM Lawsuit against the City of Detroit or property of the City of Detroit.

6. The Court shall retain jurisdiction over any and all matters arising from the interpretation or implementation of this Order.

EXHIBIT 2 – NOTICE

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re: City of Detroit, Michigan, Debtor.	Bankruptcy Case No. 13-53846 Honorable Thomas J. Tucker Chapter 9

NOTICE OF OPPORTUNITY TO OBJECT TO CITY OF DETROIT'S MOTION TO ENFORCE ORDER, PURSUANT TO SECTIONS 105, 501, AND 503 OF THE BANKRUPTCY CODE AND BANKRUPTCY RULES 2002 AND 3003(c), ESTABLISHING BAR DATES FOR FILING PROOFS OF CLAIM AND APPROVING FORM AND MANNER OF NOTICE THEREOF AGAINST AMERICAN ANESTHESIA ASSOCIATES, LLC AND SPINE SPECIALISTS OF MICHIGAN, P.C.

The City of Detroit has filed its Motion to Enforce Order, Pursuant to Sections 105, 501, and 503 of the Bankruptcy Code and Bankruptcy Rules 2002 and 3003(c), Establishing Bar Dates for Filing of Proofs of Claim and Approving Form and Manner of Notice Thereof Against American Anesthesia Associates, LLC and Spine Specialists of Michigan, P.C.

Your rights may be affected. You should read these papers carefully and discuss them with your attorney.

If you do not want the Court to enter an Order granting the Motion to Enforce Order, Pursuant to Sections 105, 501, and 503 of the Bankruptcy Code and Bankruptcy Rules 2002 and 3003(c), Establishing Bar Dates for Filing of Proofs of

Claim and Approving Form and Manner of Notice Thereof Against American Anesthesia Associates, LLC and Spine Specialists of Michigan, P.C., within 14 days, you or your attorney must:

1. File with the court a written response or an answer, explaining your position at:[1]

United States Bankruptcy Court
211 W. Fort St., Suite 1900
Detroit, Michigan 48226

If you mail your response to the court for filing, you must mail it early enough so that the court will **receive** it on or before the date stated above. You must also mail a copy to:

Miller, Canfield, Paddock & Stone, PLC
Attn: Marc N. Swanson
150 West Jefferson, Suite 2500
Detroit, Michigan 48226

2. If a response or answer is timely filed and served, the clerk will schedule a hearing on the motion and you will be served with a notice of the date, time, and location of that hearing.

If you or your attorney do not take these steps, the court may decide that you do not oppose the relief sought in the motion or objection and may enter an order granting that relief.

[1] Response or answer must comply with F. R. Civ. P. 8(b), (c) and (e).

MILLER, CANFIELD, PADDOCK AND STONE, P.L.C.

By: /s/ Marc N. Swanson

Marc N. Swanson (P71149)
150 West Jefferson, Suite 2500
Detroit, Michigan 48226
Telephone: (313) 496-7591
Facsimile: (313) 496-8451
swansonm@millercanfield.com

Dated: October 6, 2016

EXHIBIT 3 – NONE

EXHIBIT 4 – CERTIFICATE OF SERVICE

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:	Bankruptcy Case No. 13-53846
City of Detroit, Michigan,	Honorable Thomas J. Tucker
Debtor.	Chapter 9

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on October 6, 2016, he served a copy of the foregoing **CITY OF DETROIT'S MOTION TO ENFORCE ORDER, PURSUANT TO SECTIONS 105, 501, AND 503 OF THE BANKRUPTCY CODE AND BANKRUPTCY RULES 2002 AND 3003(c), ESTABLISHING BAR DATES FOR FILING PROOFS OF CLAIM AND APPROVING FORM AND MANNER OF NOTICE THEREOF AGAINST AMERICAN ANESTHESIA ASSOCIATES, LLC AND SPINE SPECIALISTS OF MICHIGAN, P.C.** upon the person listed below via first class mail and email:

Counsel to American Anesthesia Associates LLC

Gerald K. Paulovich
Anthony & Paulovich, PLLC
2000 Town Center, Suite 1900
Southfield, Michigan 48075
gp@anthonylitigation.com

Counsel to Spine Specialists of Michigan, P.C.
Jarrod K. Anthony
Anthony & Paulovich, PLLC
2000 Town Center, Suite 1900
Southfield, Michigan 48075
janthony@anthonylitigation.com

DATED: October 6, 2016

By: /s/ Marc N. Swanson

Marc N. Swanson (P71149)
150 West Jefferson, Suite 2500
Detroit, Michigan 48226
Telephone: (313) 496-7591
Facsimile: (313) 496-8451
swansonm@millercanfield.com

EXHIBIT 5 – NONE

EXHIBIT 6A – SSM COMPLAINT

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	SUMMONS AND COMPLAINT	CASE NO. 16-009119-NF Hon. John A. Murphy

2 Woodward Ave., Detroit MI 48226 — Court Telephone No. 313-224-0142

Plaintiff	Defendant
Spine Specialists of Michigan, P.C. (Carrie McDonald)	City of Detroit Law Department
Plaintiff's Attorney Jarrod Keden Anthony, P-75973 2000 Town Ctr Ste 1900 Southfield, MI 48075-1152	**Defendant's Attorney**

RECEIVED
JUL 25 2016
CITY OF DETROIT
LAW DEPARTMENT

SUMMONS **NOTICE TO THE DEFENDANT:** In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons to **file a written answer with the court** and serve a copy on the other party or **take other lawful action with the court** (28 days if you were served by mail or you were served outside this state). (MCR 2.111[C])
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

Issued	This summons expires	Court clerk
7/20/2016	10/19/2016	File & Serve Tyler

*This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

COMPLAINT ***Instruction: The following is information that is required to be in the caption of every complaint and is to be completed by the plaintiff. Actual allegations and the claim for relief must be stated on additional complaint pages and attached to this form.***

☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035.

Family Division Cases

☐ There is no other pending or resolved action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties.

☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

General Civil Cases

☐ There is no other pending or resolved civil action arise out of the same transaction or occurrence as alleged in the complaint.

☒ An civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in _____ Court.

The action ☒ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

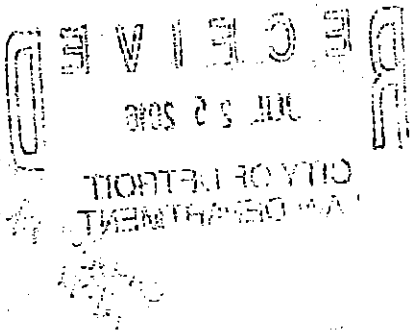
Docket no.	Judge	Bar no.
16-008713-CZ	John A. Murphy	24492

VENUE

Plaintiff(s) residence (include city, township, or village)	Defendant(s) residence (include city, township, or village)
Place where action arose or business conducted	

Date _____ Signature of attorney/plaintiff _____

If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.


RECEIVED
JUL 25 2016
CITY OF DETROIT
LAW DEPARTMENT

jp

STATE OF MICHIGAN

IN THE 3rd CIRCUIT COURT FOR THE COUNTY OF WAYNE

SPINE SPECIALISTS OF MICHIGAN, P.C.
(Carrie McDonald

Plaintiff,

File No. -NF
Honorable

v.

CITY OF DETROIT LAW DEPARTMENT

Defendant.

16-009119-NF
FILED IN MY OFFICE
WAYNE COUNTY CLERK
7/20/2016 8:29:48 AM
CATHY M. GARRETT

JARROD K. ANTHONY (P75973)
ANTHONY & PAULOVICH, PLLC
Attorneys for Spine Specialists
2000 Town Center, Suite 1900
Southfield, Michigan 48075
(248) 351-1747; Fax: (888) 578-9826
janthony@anthonylitigation.com

There is another pending civil action out of the same transaction or occurrence as alleged in the complaint in Wayne County Circuit Court, Case No. 16-008713-CZ, and is assigned to Judge John A. Murphy.

SPINE SPECIALISTS OF MICHIGAN, P.C'S COMPLAINT AGAINST DEFENDANT CITY OF DETROIT LAW DEPARTMENT

NOW COMES Plaintiff, SPINE SPECIALISTS OF MICHIGAN, P.C., by and through their attorneys, Anthony & Paulovich, PLLC., through undersigned counsel, Jarrod K, Anthony, and for their Complaint states as follows:

JURISDICTION / VENUE ALLEGATIONS

1. Plaintiff, SPINE SPECIALISTS OF MICHIGAN, P.C., (hereinafter 'Spine Specialists of Michigan') is a Michigan Corporation whose principal place of business is in the City of Bingham Farms, County of Oakland.

2. Defendant, CITY OF DETROIT, is a municipality in the State of Michigan, that regularly conducts business and/or is otherwise established in Wayne County, State of Michigan.

3. The amount in controversy herein exceeds $25,000 and is otherwise within the jurisdiction of this Honorable Court.

COUNT I - STATUTORY VIOLATIONS OF THE MICHIGAN NO-FAULT ACT

4. Plaintiff hereby incorporates by reference each and every allegation contained in paragraphs 1 through 3 as though fully stated herein.

5. On or about May 23, 2013, Carrie McDonald (the "Injured Party") was involved in an automobile accident arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle.

6. Defendant is first in order of priority to pay for the Injured Party's claim for no fault personal protection insurance benefits in accordance with Chapter 31 of the Michigan Insurance Code, more commonly known as the "no fault insurance law".

7. Defendant assigned claim number A32950002697 to the Injured Party's claim.

8. Under the terms and conditions Michigan No-Fault Automobile Insurance Act MCL 500.3101 et seq. (hereinafter referred to as 'No-Fault Act'), Defendant became obligated to pay to or on behalf of the Injured Party's certain expenses and losses if they sustained accidental bodily injuries in an accident arising out of the ownership, operation, maintenance, or use of a motor vehicle during the policy period.

9. Because the subject accident occurred during the policy period, Defendant became obligated to pay for certain expenses incurred for reasonably necessary products and services rendered for the Injured Party's care, recovery or rehabilitation as a result of the Injured Party's accidental bodily injuries arising out of the ownership, operation, maintenance or use of a motor

vehicle as a motor vehicle.

10. On numerous dates, Plaintiff provided medical treatment to the Injured Party for injuries they suffered as a result of the subject accident.

11. Plaintiff sought recovery from Defendant for the above stated personal protection benefits pursuant to the No-Fault Act.

12. Plaintiff has fully complied with the requirements of the applicable contract of insurance and the No-Fault Act, and has provided Defendant with reasonable proof of all outstanding medical expense benefits owed at this time.

13. Defendant has refused to pay Plaintiff necessary and incurred expenses related to the Injured Party's medical care in accordance with the contract provisions and the No-Fault Act.

14. By wrongfully denying Plaintiff's claims, Defendant breached its statutory duty and is liable for that amount of coverage to which Plaintiff is rightfully entitled.

WHEREFORE, Plaintiff, SPINE SPECIALISTS OF MICHIGAN, P.C, prays for a Judgment against Defendant, CITY OF DETROIT LAW DEPARTMENT in such an amount as the trier of fact shall determine to be fair and just, together with all past and presently owed no-fault benefits, interest, costs, no-fault penalty interest and no-fault penalty attorney fees.

Respectfully submitted,
ANTHONY & PAULOVICH, PLLC

/s/ Jarrod K. Anthony
Jarrod K. Anthony P75973
Attorney for Plaintiff, Spine Specialists of Michigan

Dated: July 19, 2016

ANTHONY & PAULOVICH
ATTORNEYS AT LAW

RECEIVED
JUL 25 2016
CITY OF DETROIT
LAW DEPARTMENT

July 21, 2016

Certified Mail mc

VIA CERTIFIED MAIL - 70160750000003605514/
RETURN RECEIPT REQUESTED

City of Detroit Law Department
2 Woodward Avenue, 5th Floor
Detroit, MI 48226

Re: Spine Specialists of Michigan, P.C. v City of Detroit
3rd Circuit Court Case No. 16-009119-NF

To Whom It May Concern:

Enclosed herewith for service please find a Summons and Complaint regarding the above referenced matter. You have twenty-eight (28) days to file responsive pleadings as to the Summons and Complaint.

If you should have any questions or concerns, please do not hesitate to contact my office.

Very Truly Yours,
Anthony & Paulovich, P.L.L.C.

Jarrod K. Anthony, Esq.
Attorney & Counselor at Law

JKA/aak
Enclosure

Phone: 248-351-1747 | 2000 Town Center, Suite 1900, Southfield, MI, 48075

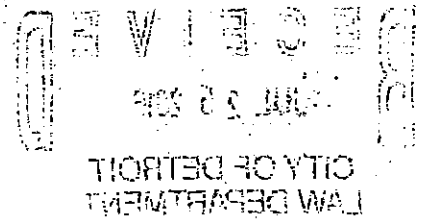

CITY OF DETROIT
LAW DEPARTMENT

EXHIBIT 6B – AAS COMPLAINT

Approved, SCAO | Original - Court; 1st copy - Defendant | 2nd copy - Plaintiff; 3rd copy - Return

STATE OF MICHIGAN 36th JUDICIAL DISTRICT JUDICIAL CIRCUIT COUNTY PROBATE	SUMMONS AND COMPLAINT Amended	CASE NO. 15119415

Court address: 421 Madison Avenue, Detroit, MI 48226 | Court telephone no.: (313) 965-4158

Plaintiff's name(s), address(es), and telephone no(s).	v	Defendant's name(s), address(es), and telephone no(s).
AMERICAN ANESTHESIA ASSOCIATES, LLC (Carrie McDonald)		CITY OF DETROIT

Plaintiff's attorney, bar no., address, and telephone no.
GERALD K. PAULOVICH (P77573)
ANTHONY LITIGATION, PLLC
2000 Town Center, Suite 1900
Southfield, MI 48075-1221
(248) 351-1747

SUMMONS NOTICE TO THE DEFENDANT: In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons to **file a written answer with the court** and serve a copy on the other party **or take other lawful action with the court** (28 days if you were served by mail or you were served outside this state). (MCR 2.111[C])
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

Issued	This summons expires	Court clerk
9/15/15	12/15/15	

*This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

COMPLAINT ***Instruction: The following is information that is required to be in the caption of every complaint and is to be completed by the plaintiff. Actual allegations and the claim for relief must be stated on additional complaint pages and attached to this form.***

☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035.

Family Division Cases

☐ There is no other pending or resolved action within the jurisdiction of the family division of circuit court involving the family or family members of the parties.

☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

General Civil Cases

☐ There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.

☑ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in Wayne County Circuit Court.

The action ☐ remains ☑ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.
12-015160-NF	Susan D. Borman	

VENUE

Plaintiff(s) residence (include city, township, or village)	Defendant(s) residence (include city, township, or village)
Place where action arose or business conducted	

09/21/2015
Date

Signature of attorney/plaintiff

If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

STATE OF MICHIGAN

IN THE 36TH JUDICIAL DISTRICT COURT

AMERICAN ANESTHESIA ASSOCIATES, LLC (Carrie McDonald),

Plaintiff,

Case No. 2015-119415-GC
HON.

v.

CITY OF DETROIT,

Defendant.

2015 SEP 21 PM 3:07

36TH DISTRICT

GERALD K. PAULOVICH (P77535)
Anthony Litigation, PLLC
Attorneys for Plaintiff
2000 Town Center, Suite 1900
Southfield, Michigan 48075
Telephone: (248) 351-1747
Fax: (888) 578-9826

A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in Wayne County Circuit Court, where it was given docket number 12-015160-NF and was assigned to Judge Susan D. Borman. This action is no longer pending.

FIRST AMENDED COMPLAINT

NOW COMES Plaintiff, AMERICAN ANESTHESIA ASSOCIATES, LLC, by and through its attorneys, ANTHONY LITIGATION, PLLC, and complaining against the above named Defendant, respectfully represents unto this Honorable Court as follows:

1. Plaintiff, AMERICAN ANESTHESIA ASSOCIATES, LLC, is a Michigan Corporation whose principal place of business is in the City of

Southfield, County of Oakland.

2. That Defendant, CITY OF DETROIT, is in the business of selling automobile insurance, and regularly conducts business and/or is otherwise established in the County of Wayne, State of Michigan.

3. The amount in controversy herein does not exceed $25,000 and is otherwise within the jurisdiction of this Honorable Court.

COUNT I - STATUTORY VIOLATIONS OF THE MICHIGAN NO-FAULT ACT

4. Plaintiff hereby incorporates by reference each and every allegation contained in paragraphs 1 through 3 as though fully stated herein.

5. Defendant is first in order of priority to pay for the injured party's claim for no fault personal protection insurance benefits in accordance with Chapter 31 of the Michigan Insurance Code, more commonly known as the "no fault insurance law".

6. Defendant assigned claim number A32950002697 to the injured party's claim.

7. The above said automobile insurance policy contained the standard no-fault provisions pursuant to MCL 500.3101 et seq.

8. Under the terms and conditions of Michigan No-Fault Automobile Insurance Act MCL 500.3101 et seq. (hereinafter referred to as 'No-Fault Act'), Defendant became obligated to pay to or on behalf of Carrie McDonald certain expenses and losses she sustained accidental bodily injuries in an accident arising out of the ownership, operation,

maintenance, or use of a motor vehicle during the policy period.

9. On or about May 23, 2012, Carrie McDonald did sustain accidental bodily injuries in an accident arising out of the ownership, operation, maintenance, or use of a motor vehicle.

10. On numerous dates, the Plaintiff provided medical treatment to Carrie McDonald, for injuries she suffered as a result of the May 23, 2012, accident. As of a result of her injuries there is due and owing the sum of $20,020.90. (See Attached Exhibit 'A' - copy of billing invoices from Plaintiff to Defendant).

11. Plaintiff sought recovery from Defendant for the above stated personal protection benefits pursuant to the No-Fault Act.

12. Plaintiff has fully complied with the requirements of the applicable contract of insurance and the No-Fault Act, and has provided Defendant with reasonable proof of all outstanding medical expense benefits owed at this time.

13. Defendant has refused to pay Plaintiff necessary and incurred expenses at a reasonable and customary rate related to claimant Carrie McDonald's medical care in accordance with the contract provisions and the No-Fault Act.

14. By wrongfully denying Plaintiff's claims, Defendant breached its statutory duty and is liable for that amount of coverage to which Plaintiff is rightfully entitled.

WHEREFORE, Plaintiff, AMERICAN ANESTHESIA ASSOCIATES, LLC,

prays for a Judgment against Defendant, CITY OF DETROIT, for $20,020.90, together with all past and presently owed no-fault benefits, interest, costs, no-fault penalty interest and no-fault penalty attorney fees.

Respectfully submitted,

GERALD K. PAULOVICH, P77535
Anthony Litigation, PLLC
Attorney for Plaintiff
2000 Town Center, Ste. 1900
Southfield, MI 48075
(248) 351-1747

Dated: September 21, 2015

CITY OF DETROIT LAW DEPT
2 WOODWARD AVE STE 500

DETROIT MI 48226-3437

A32950002697

MCDONALD CARRIE J

[redacted]

MCDONALD CARRIE J

636 ST AUBIN

636 ST AUBIN

DETROIT MI

DETROIT MI

48207 313 7531013

48207 313 7531013

[redacted]

MI

CITY OF DETROIT LAW DEPT

SIGNATURE ON FILE 10 15 14

SIGNATURE ON FILE

05 23 13 431

439 05 23 13

DN LOUIS RADDEN DO 1184675886

0 00

72210

7 Begin 12:30 End 13:30

09 23 14 09 23 14 11 01936 02 A 6435 45 60 1063466928

[redacted]

6435 45 0 00

DAVID C WHITESELL CRNA

SPINE SPECIALIST OF MICHI
32270 TELEGRAPH RD
BINGHAM FAR MI 48025-2456

313 4998117
AMERICAN ANESTHESIA ASSOCIATES
22200 W 11 MILE RD STE 201
SOUTHFIELD MI 48037-7000

10 18 14

1891822565

1083959548

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CITY OF DETROIT W/C **
RISK MANAGEMENT
2 WOODWARD AVE-STE 611
DETROIT MI 48226

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): A32950002697
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE	3. PATIENT'S BIRTH DATE [redacted] SEX: F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE	
5. PATIENT'S ADDRESS (No., Street): 636 ST AUBIN	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 636 ST AUBIN	
CITY: DETROIT STATE: MI	8. RESERVED FOR NUCC USE
CITY: DETROIT STATE: MI	
ZIP CODE: 48207 TELEPHONE (Include Area Code): (313) 7531013	
ZIP CODE: 48207 TELEPHONE (Include Area Code): (313) 7531013	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: A32950002697	a. EMPLOYMENT? (Current or Previous) NO
a. INSURED'S DATE OF BIRTH [redacted] SEX: M F X	
b. RESERVED FOR NUCC USE [redacted]	b. AUTO ACCIDENT? YES NO PLACE (State): MI
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: CITY OF DETROIT W/C **	
d. INSURANCE PLAN NAME OR PROGRAM NAME: PADILLA ATTY LAW GROUP **	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO — If yes, complete items 9, 9a and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — DATE: 10 08 14

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 12 13 QUAL 431	15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN RADDEN, LOUIS	17a. 17b. NPI 1184675886
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 9: A. 722.10 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
ANES TIME 12.20-13.25											
1 10 08 14	10 08 14	11		01936	QZ	A	7150 00	01		NPI	1063466928
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 46-1506928	26. PATIENT'S ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 7150 00	29. AMOUNT PAID $ 00	30. Rsvd for NUCC use 7150 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) DAVID WHITESELL, CRNA SIGNED 08	32. SERVICE FACILITY LOCATION INFORMATION: SPINE SPECIALISTS OF MICH 28426 W 8 MI RD, UNIT A4 FARMINGTON HILLS MI 48336- a 1891822565 b		33. BILLING PROVIDER INFO & PH. # (734) 241-3891: AMERICAN ANESTHESIA ASSOC LLC 5623 E. DUNBAR ROAD MONROE MI 48161-9127 a 1083959548 b		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB 0938-1197 FORM 1500 (02-12)

DET RISK — WCMS-1500CS-12

CITY OF DETROIT LAW DEPT
2 WOODWARD AVE STE 500

DETROIT MI 48226-3437

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): A32950002697

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE J	3. PATIENT'S BIRTH DATE [redacted] SEX M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE J
5. PATIENT'S ADDRESS (No., Street): 636 ST AUBIN	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street): 636 ST AUBIN
CITY: DETROIT STATE: MI	8. RESERVED FOR NUCC USE	CITY: DETROIT STATE: MI
ZIP CODE: 48207 TELEPHONE (Include Area Code): (313) 7531013		ZIP CODE: 48207 TELEPHONE (Include Area Code): (313) 7531013
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INS [redacted] SEX M F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? X YES NO PLACE (State) MI	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: CITY OF DETROIT LAW DEPT
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 09 12 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 23 13 QUAL. 431	15. OTHER DATE QUAL 439 MM DD YY: 05 23 13	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN LOUIS RADDEN DO	17a. 17b. NPI 1184675886	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO $ CHARGES: 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9: A. 72210 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7 Begin 09:15 End 10:15										
1 09 08 15 09 08 15	11		01936	QZ P3	A	6435 45	60		NPI	1114177656
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 461506928 SSN EIN X	26. PATIENT'S ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 6435 45	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) TERRY KIMBERLY CRNA	32. SERVICE FACILITY LOCATION INFORMATION: SPINE SPECIALIST OF MICHI 32270 TELEGRAPH RD BINGHAM FAR MI 48025-2456		33. BILLING PROVIDER INFO & PH # (313) 4998117: AMERICAN ANESTHESIA ASSOCIATES 22200 W 11 MILE RD STE 201 SOUTHFIELD MI 48037-7000		
SIGNED 09 12 15 DATE	a 1891822565 b		a 1083959548 b		

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

EXHIBIT 6C – PROOF OF CLAIM

Claim #1542 Date Filed: 2/19/2014

In its List of Claim
in an unknown amount. To determine if you need to file a claim, please refer to the enclosed Information About Deadlines to File Claims.

B10 (Official Form 10) (04/13) (Modified)

FILED

FEB 19 2014

US Bankruptcy Court
MI Eastern District

UNITED STATES BANKRUPTCY COURT EASTERN DISTRICT of MICHIGAN

CHAPTER 9 PROOF OF CLAIM

Name of Debtor: City of Detroit, Michigan | Case Number: 13-53846

NOTE: *Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing.*

Name of Creditor (the person or other entity to whom the debtor owes money or property):
Mcdonald, Carrie

COURT USE ONLY

Name and address where notices should be sent: NameID: 11702538

Mcdonald, Carrie
25657 Southfield Rd
Southfield, MI 48075

Telephone number: 248-350-9050 email: brett@55mikewins.com

☐ Check this box if this claim amends a previously filed claim.

Court Claim Number: _____ (*if known*)

Filed on: _____

Name and address where payment should be sent (if different from above):

Telephone number: email:

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

RECEIVED
FEB 24 2014
KURTZMAN CARSON CONSULTANTS

1. Amount of Claim as of Date Case Filed: $ 98,392.43

If all or part of the claim is secured, complete item 4.
If all or part of the claim is entitled to priority, complete item 5.
☐ Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.

2. Basis for Claim: PIP claim due to 5/23/12 bus crash.
(See instruction #2)

3. Last four digits of any number by which creditor identifies debtor:

3a. Debtor may have scheduled account as:
(See instruction #3a)

4. Secured Claim (See instruction #4)
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any: $

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe:

Basis for perfection:

Value of Property: $

Amount of Secured Claim: $

Annual Interest Rate (when case was filed) ____% ☐ Fixed or ☐ Variable

Amount Unsecured: $

5. Amount of Claim Entitled to Priority as an Administrative Expense under 11 U.S.C. §§ 503(b)(9) and 507(a)(2). $

5b. Amount of Claim Otherwise Entitled to Priority. Specify Applicable Section of 11 U.S.C. § _____ $

6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)

7. Documents: Attached are **redacted** copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and **redacted** copies of documents providing evidence of perfection of a security interest are attached. *(See instruction #7, and the definition of "redacted".)* DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.
If the documents are not available, please explain:

8. Signature: (See instruction # 8)
Check the appropriate box.

☐ I am the creditor. ☒ I am the creditor's authorized agent. ☐ I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Brett O'Shell
Title: Attorney
Company: Law Office of Michael Morse PC
Address and telephone number (if different from notice address above):
24901 Northwestern Hwy., Suite 700
Southfield, MI 48075
Telephone number: email:

(Signature) 2/7/14 (Date)

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

mikemorselawfirm
855-MIKE-WINS

ATTORNEYS AT LAW
Michael J. Morse
Marc J. Mendelson
Eric M. Simpson
Donald J. Cummings
Perry A. Schneider
Robert S. Silverman
Matthew R. Bates
Jacob K. Yeater
Anthony H. Chapman
Christopher D. Filiatraut
Jennifer G. Damico
Dalit Oren
Nicholas J. Caponigro
Lewis A. Melfi
Helen A. Manesia
Paul F. Hesselgrave
Patty A. Dooley
Paul E. Wheatley
Brett F. O'Shell
Meaghan B. McKay
Brian R. Meyer
James B. Wendt
Andrew J. Kata
Gregory A. Jones
David D. O'Keefe
Monika J. Carter
Patrick A. Moritz
Patrick C. Cassidy
Christopher T. Immel
Catherine Groll
Joshua B. Farr
Shawn P. McKay
Ashleigh Weinbrecht
Jenna R. McKenna
James A. Lane

February 5, 2014

Settlement Demand Package
Office of the Clerk of Court
United States Bankruptcy Court
For the Eastern District of Michigan
211 West Fort St.
Suite 1700
Detroit, MI 48226

Our Client:	**Carrie McDonald**
Date of Crash:	**5/23/12**
Claim No:	[redacted]**2697**

To Whom It May Concern,

Please allow this to be a demand for payment of the below described PIP benefits against the City of Detroit:

Cause of Action:	This action involves a first-party claim for No-Fault PIP benefits, by Carrie McDonald against Defendant, City of Detroit.
Collision:	Carrie was a passenger on a DDOT bus that was struck by a negligent hit and run driver. **(Exhibit 1)**
Date of Occurrence:	May 23, 2102
Plaintiff:	**Carrie McDonald,** age 45, was an extremely independent woman prior to this crash with no previous neck or back injuries.
Defendants:	City of Detroit (PIP carrier)
Injuries:	Cervical injuries, lumbar injuries, right hip injury, and intracranial bleeding requiring re-coiling of aneurysm.

Medical Treatment

On the day of this crash, Carrie was scene at Detroit Receiving hospital where she complained of pain her neck, back, and head. She was examined, prescribed Flexiril, and instructed to see her primary care physician.

On May 25, 2012, Carrie began treatment with Dr. Ryan Lukowski, to whom she reported headaches, neck pain, and back pain. During a physical examination, Dr. Lukowski noted limited range of motion, tenderness, and muscle spasms in the cervical, thoracic and lumbar spine. Dr. Lukowski disabled her from work and household chore activities involving lifting, bending, twisting, and prolonged standing and sitting and started her on a course of chiropractic treatment. **(Exhibit 2)**

On May 31, 2012 Carrie saw Dr. Noel Upfall, an internist, to who she reported headaches, hip pain, back pain radiating into her legs, and neck pain radiating to her shoulders. Dr. Upfall noted muscle spasm, tenderness, and decreased range of motion in the cervical and lumbar spine. He ultimately diagnosed her with cervical and lumbar sprains, prescribed Flexeril and ordered CT scans to determine if she had disk herniations. **(Exhibit 3)**

On August 14, 2012, Carrie underwent CT scan of her hip lumbar spine which revealed disk displacement at L3-L4, L4-L5, and L5-S1 with bilateral foraminal stenosis. **(Exhibit 4)**

When chiropractic care failed to resolve her pain, Carrie began treating with Dr. Louis Radden, a neurosurgeon, on October 8, 2012. She reported ongoing pain in her neck and back radiating into her extremities. Dr. Radden examined her and performed a number of invasive procedures:

- 1/16/13 – L4-L5 facet injections and L5-S1 lumbar epidural steroid injection;
- 2/13/13 – L4-L5 facet injections and L5-S1 lumbar epidural steroid injection;
- 3/13/13 – L4-L5 facet injections and L5-S1 lumbar epidural steroid injection.

(Exhibit 5)

Currently, Dr. Radden is recommending low back surgery and Carrie is scheduled to undergo a discogram for surgical planning.

For her hip pain, Carrie saw orthopedic surgeon, Dr. Mark Kwartowitz on April 2, 2013. Dr. Kwartowitz conducted an examination and administered a cortisone injection in her right hip.

Presently, Carrie remains disabled and will require a low back surgery. Her injuries have not resolved to this day.

Defense Medical Examinations

On September 13, 2012, Carrie saw Dr. Richard Ikla, who performed an evaluation at Defendant's request. He conducted record review and examination and concluded the following:

> Ms. McDonald sustained trauma in a bus/truck accident in May 2012 and was not seen until later after she developed severe headaches and was found to have an intercranial bleed, likely from a coup-countercoup force on the brain resulting in a swinging of the brain inside the cranium, causing an aneurysm to bleed. Last Friday, she was treated by the percutaneous placement of another coil, she said. *** **It is recommended that she receive physical therapy addressed to her low back complaints.**

(Exhibit 6)

On February 26, 2013, Carrie saw Dr. Christopher Schoneherr at the request of the City of Detroit. She reported continued pain in her back and neck, as well as dizziness. During a physical examination, Dr. Schoenherr noted hip pain, lumbar tenderness and limited range of motion and cervical tenderness and limited range of motion. After conducting a physical examination and record review, Dr. Schoenherr stated: "Ms. McDonald suffered a cerival and lumbar sprain/strain. It appears that secondary to the force of the injury, she may have had a coup-countercoup force causing her aneurysm to bleed for which she had a coiling..." **(Exhibit 7)**

Outstanding No-Fault PIP Benefits:

A. Medical Bills (Exhibit 8)

• Ronald S. Lederman, M.D. PLLC	$1,570.00
• Detroit Magnolia Transportation	$7,712.00
• Spine Specialists of Michigan	$16,105.00
• Michigan Center for PT	$4,350.00
• Elite Health Centers	$800.00
• Elite Chiropractic	$2,125.00
• American Anesthesia Assoc	$1,078.00
• MI Dept. of Community Health (Medicaid Lien)	$126.94
• Taxi Service	$85.00
• Ambulatory Anesthesia	$360.00
• MI Head & Spine Institute	$5,220.00
• Strictly Healing Transportation	$225.00
• R&R Transportation	$360.00
• **Total**	**$40,116.94**

B. Household Services (Exhibit 9)

Carrie has been disabled from performing household services since this crash. (Exhibit 4) Her daughter, Danielle Matlock has been assisting with chores 7 days per week from May 24, 2012 through March 31, 2013 and 5 days per week from April 1, 2013 through June 20, 2013. (Exhibit 10) The City of Detroit last reimbursed household services on June 30, 2012. Presently, there are 343 days outstanding. 343 x $20.00 per day = **$6,860.00.**

C. Wage Loss (Exhibit 10)

Carrie has been disabled from work since this crash. (Exhibit 4) She previously worked as a cook at Palm's Nightclub where she earned $10.00 per hour and worked approximately 25 hours per week. (Exhibit 11) The City of Detroit has never paid wage loss. Presently, Carrie is owed wages as follows $250.00 per week x 89 weeks x 0.85 = **$18,912.50**

Demand through the Present:

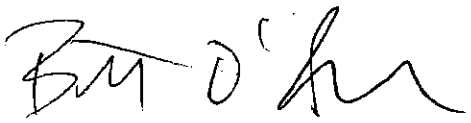
Medical Bills	$40,116.94
Household Services	$6,860.00
Wage Loss	$18,912.50
Subtotal	$65,889.44
Interest	$7,906.73
Attorney Fees	$24,596.26
Total through present	**$98,392.43**

Demand through 7/18/13:

Medical Bills	$39,766.94
Household Services	$6,860.00
Wage Loss	$12,750.00 (60 wks x $250/wk x0.85)
Subtotal	$59,376.94
Interest	$7,125.23
Attorney Fees	$22,165.17
Total through 7/18/13	**$88,667.34**

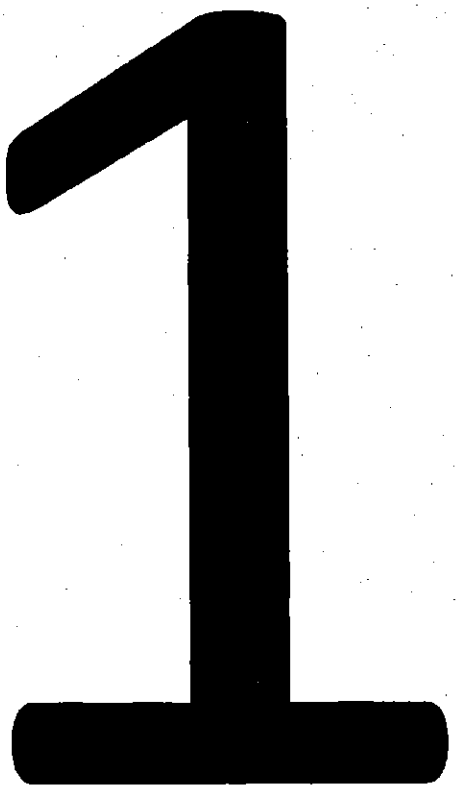
Sincerely,

LAW OFFICES OF MICHAEL J. MORSE, P.C.



Brett F. O'Shell

Enclosures



Authority: 1949 PA 300, Sec.257.622
Compliance: Required MSP UD-10E
Penalty: $100 and/or 90 days (Rev 11/2006)

External #: 228522 | Crash ID:

Page 1
Incident # 228522 File Class:
Incident Disposition: Open
Reviewer: SGT DONALD PACE (S234)

STATE OF MICHIGAN TRAFFIC CRASH REPORT

ORI: MI8234913
Department Name: Detroit Police Department

Crash Date	Crash Time	No. of Units	Crash Type	Special Circumstances	Special Checks
05/23/2012	09:30	02	Rear End	○None ● Hit and Run ○Deer ○Fleeing Police ○School Bus	○ Fatal ○ Non-Traffic Area ○ ORV/Snowmobile

County	Traffic Control	Relation to Roadway	Special Study	Weather	Area
82 - Wayne	Signal	On Road	None	Clear	10 - NON-FRWY Straight roadway

City/Twsp	Construction Zone (if applicable) Type	Lane Closed	Activity	Light	Road Condition	Total Lanes	Speed Limit	Posted
99 - Detroit				Daylight	Dry	03	30	No

LOCATION

Prefix	Road Name	Road Type	Suffix	Divided Roadway
	ROSA PARKS	AVE		

Distance (ft.)	Traffic Way	Access Control
30.0 Feet N	04 - One-way traffic	01 - No access control

Prefix	Intersecting Road	Road Type	Suffix	Divided Roadway
	WB MARTIN LUTHER KING JR	BLVD		

UNIT

Unit Number	Unit Known	State	Driver License Number	Date of Birth (Age)	License Type	Endorsements	Sex	Total Occupants	Hazardous Action
01	No				○Operator ○Chauffer ○Moped	○Cycle ○Farm ○Recreation		00	12 - Unable to stop

Unit Type	Driver Information	Injury	Position	Restraint	Hospital
MV			00	00	None

Driver Condition	Interlock	Ejected	Trapped	Airbag Deployed	Ambulance
○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ● 99	No				None

Alcohol: ○Yes ● No ○Refused ● Not Offered — Test Type ○Field ○PBT ○Breath ○Blood ○Urine — Test Results:
Drugs: ○Yes ● No — Test Type ○Blood ○Urine — Test Results:
Citation Issued: ○Hazardous ○Other

Vehicle Registration	State	Insurance/Policy #	Towed To/By #	Special Vehicles	Private Trailer Type	Vehicle Defect

VIN	Vehicle Description	Make	Model	Color	Year	Vehicle Type

Location of Greatest Damage	First Impact	Extent of Damage	Driveable	Vehicle Direction	Vehicle Use	Action Prior
11	11	00	Yes			36 - Unknown

Sequence of Events (● indicates MOST harmful event)	First	Second	Third	Fourth
	● 17 - Motor veh in transport			

PASSENGERS

Passenger Information	Date of Birth (Age)	Sex	Position	Restraint	Hospital	Injury	Airbag Deployed	Ejected	Trapped	Ambulance

05/23/2012 228522

CARRIER

Carrier Information	Carrier Source	GVWR	ICCMC	USDOT	MPSC

Driver's CDL Type — Endorsements: ○H ○P ○T ○N ○S ○X — CDL Exempt: ○Farm ○Other — CDL Restrictions: ○28 ○29 ○30 ○35 ○36

Interstate/Intrastate	Vehicle Type	Type and Axle Per Unit: First	Second	Third	Fourth	Cargo Body Type	Medical Card	Hazardous Material	ID #	Class #
								○Placard ○Cargo Spill		

OWNER

Owner Information	Owner Information

Person Advised of Damaged Traffic Control
Contact Name :
Contact Date :
Contact Time :

Damaged Property | Public
Owner and Phone

Unit Number	Unit Known	State	Driver License Number	Date of Birth(Age)	License Type	Endorsements	Sex	Total Occupants	Hazardous Action
02	Yes	MI	[redacted]8093	[redacted]1961 (51)	O Operator ● Chauffer O Moped	O Cycle O Farm O Recreation	M	10	00 - None

Unit Type	Driver Information	Injury	Position	Restraint	Hospital
MV	JAMES LAJUAHN FOUNTAIN [redacted]	O	01	04	None

Driver Condition	Interlock	Ejected	Trapped	Airbag Deployed	Ambulance
● 1 O2 O3 O4 O5 O6 O7 O8 O9 O99	No			Not equipped	REFUSD

Alcohol	Test Results	Drugs	Test Results	Citation Issued
OYes ● No ORefused ● Not Offered; Test Type OField OPBT OBreath OBlood Urine		OYes ● No; Test Type OBlood OUrine		OHazardous OOther

Vehicle Registration	State	Insurance/Policy #	Towed To/By #	Special Vehicles	Private Trailer Type	Vehicle Defect
083X070	MI	CITY OF DETROIT - SELF INSURED	R.T.D.	3		

VIN	Vehicle Description	Make	Model	Color	Year	Vehicle Type
5FYD44FV16AB03700		NEW FLYER	BUS	WHI	2010	Truck/Bus

Location of Greatest Damage	First Impact	Extent of Damage	Driveable	Vehicle Direction	Vehicle Use	Action Prior
06	06	01	Yes	N	08 - Other Government Use	04 - Stopped on roadway

Sequence of Events (● indicates MOST harmful event)	First	Second	Third	Fourth
	● 17 - Motor veh in transport			

PASSENGERS

Passenger Information	Date of Birth (Age)	Sex	Position	Restraint	Hospital	Injury	Airbag Deployed	Ejected	Trapped	Ambulance
CARRIE JOHNELL MCDONALD [redacted]	[redacted]1968 (44)	F	11	05	830500	C	Not equipped			821064

Carrier Information	Carrier Source	GVWR	ICCMC	USDOT	MPSC
CITY OF DETROIT DOT 1301 WARREN Ave DETROIT MI 48207	Vehicle	42,540		000000000000	000000000000

Driver's CDL Type	Endorsements	CDL Exempt	CDL Restrictions
Group A	OH ● P OT ON OS OX	OFarm OOther	O28 O29 O30 O35 O36

Interstate/Intrastate	Vehicle Type	Type and Axle Per Unit First	Second	Third	Fourth	Cargo Body Type	Medical Card	Hazardous Material	ID #	Class #
Intrastate	BP	B2				8	Yes	OPlacard OCargo Spill		

Owner Information	Owner Information
CITY OF DETROIT DOT 1301 E WARREN AVE DETROIT MI 48207 (313)933-1300	

Witness Information	Witness Information

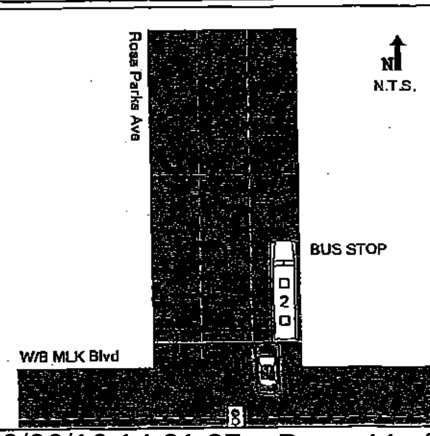
Investigated at Scene	Reported Date (Time)	1st Investigator Name (Badge)	2nd Investigator Name (Badge)	Photo By
Yes	05/23/2012(10:48)	CHRISTOPHER THERSSEN (4039)		

Narrative

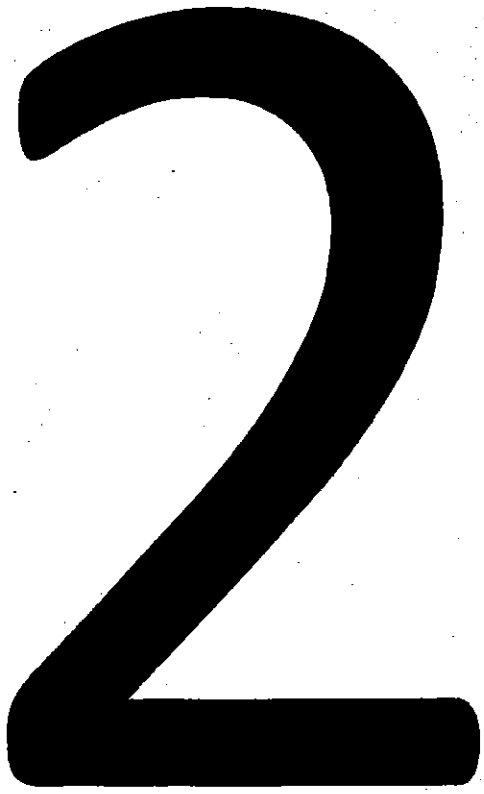
I arrived at the above location, W/B Martin Luther King Blvd at Rosa Parks Ave, and spoke to Driver #2. Per Driver #2 he was traveling N/B Rosa Parks Ave and stopped at the right curb "Bus Stop" n/o W/B Martin Luther King Blvd to pick-up passengers. Per Driver #2 while stopped Vehicle #2 was struck by an unk type Lt Blue Minivan, Vehicle #1, who then fled the location without identifying self. Vehicle #2 (Pos #11 - near front of bus behind driver) was conveyed to DRH via Medic #13 for lower back pain - per Dr. Loynd, Cht #369822691, Temp Serious.

External #: 228522
Incident #: 228522

Diagram



05/23/2012 228522



ELITE
HEALTH CENTERS

Elite Health Centers
7700 2nd Ave Suite 410 Detroit MI 48202 P:313-986-1100 F: 313-338-3082

Disability Certificate

Re: Carrie McDonald — PATIENT NAME
5/23/12 — DATE OF ACCIDENT

DIAGNOSIS/DIAGNOSIS CODE(s): 784.0, 729.1, 7242

DIAGNOSIS SECONDARY TO MVA: ☑

I have examined and/or treated the above-named patient for injuries sustained in the aforementioned accident. As a result of the injuries received in this accident, ***I have disabled the patient from those activities that are marked with and "X" or the paragraphs with a start date of*** 4/13/13 ***and end date of*** 5/13/13 ***or until the patient's next appointment.***

____ **(1) Work/Employment Disability**

__X__ **(2) Work Restrictions:** The patient is restricted from lifting more than _____lbs, and also cannot: _____.

__X__ **(3) "Housework" or replacement services:** As some housework may involve bending, lifting, twisting, and prolonged standing, i.e. vacuuming, making beds, yard work, cooking, washing floors, sinks, bathtubs, toilets, moving furniture, picking up objects off floors, child care, carrying garbage or groceries, etc., it is my opinion that the patient cannot do housework and has been disabled based on the start and end listed above or until the patient's next appointment.

_____ **(4) Attendant Care:** The patient needs help taking care of his/her own personal needs including, but not limited to, dressing using the restroom, supervising, driving to/from doctor appointments, carrying, passing medication, assisting with bathing, changing bandages, cleaning bandages, lifting, fetching, taking grooming needs, anything needing patient to bend or twist, feeding, cooking meals, ambulating all general hygiene needs. It is my opinion that the patient needed these services _____ hours per day, _____ days per week from the start and end dates listed above or until the patient's next appointment.

__X__ **(5) Driving:** The patient is unable to drive and requires transportation services.

__X__ **(6) Recreational Activities:** The patient should not engage or attempt to engage in activities that would aggravate his/her underlying condition by lifting greater than the amount indicated above, excessive bending, twisting, turning, or prolonged standing or sitting, i.e. running, climbing, biking, wrestling, etc.

Physician's Signature: Michael P. Draplin — Today's Date: 4/18/13

Print Name Michael Draplin D.C.

ELITE
HEALTH CENTERS
Elite Health Centers
7700 2nd Ave Suite 410 Detroit MI 48202 P:313-986-1100 F: 313-338-3082

Disability Certificate

Re: Carrie McDonald (PATIENT NAME) 5/23/12 (DATE OF ACCIDENT)

DIAGNOSIS/DIAGNOSIS CODE(s): 784.0, 729.1, 724.2

DIAGNOSIS SECONDARY TO MVA: ☑

I have examined and/or treated the above-named patient for injuries sustained in the aforementioned accident. As a result of the injuries received in this accident, ***I have disabled the patient from those activities that are marked with and "X" or the paragraphs with a start date of*** 3/12/13 ***and end date of*** 4/12/13 ***or until the patient's next appointment.***

____ **(1) Work/Employment Disability**

X **(2) Work Restrictions:** The patient is restricted from lifting more than _____lbs, and also cannot: _____

X **(3) "Housework" or replacement services:** As some housework may involve bending, lifting, twisting, and prolonged standing, i.e. vacuuming, making beds, yard work, cooking, washing floors, sinks, bathtubs, toilets, moving furniture, picking up objects off floors, child care, carrying garbage or groceries, etc., it is my opinion that the patient cannot do housework and has been disabled based on the start and end listed above or until the patient's next appointment.

____ **(4) Attendant Care:** The patient needs help taking care of his/her own personal needs including, but not limited to, dressing using the restroom, supervising, driving to/from doctor appointments, carrying, passing medication, assisting with bathing, changing bandages, cleaning bandages, lifting, fetching, taking grooming needs, anything needing patient to bend or twist, feeding, cooking meals, ambulating all general hygiene needs. It is my opinion that the patient needed these services_____ hours per day, _____ days per week from the start and end dates listed above or until the patient's next appointment.

X **(5) Driving:** The patient is unable to drive and requires transportation services.

X **(6) Recreational Activities:** The patient should not engage or attempt to engage in activities that would aggravate his/her underlying condition by lifting greater than the amount indicated above, excessive bending, twisting, turning, or prolonged standing or sitting, i.e. running, climbing, biking, wrestling, etc.

Physician's Signature: Michael P. Draplin Today's Date: 3/12/13

Print Name Michael Draplin D.C.

Elite Health Centers, INC.
7700 2nd Ave.
Detroit, MI. 48202
Phone: (313) 986-1100 Fax: (313) 338-3082

Disability Certificate

Re: Carrie McDonald (PATIENT NAME) 5/22/12 (DATE OF ACCIDENT)

I have examined and/or treated the above-named patient for injuries sustained in the above accident. As a result of the injuries received in this accident, ***I have disabled and/or restricted the patient from those activities marked with and "X" or the paragraphs with dates imputed:***

X (1) **Work/Employment Disability:** The patient has been on work disability from 7/26/12 through 8/25/12.

_____(2) **Work Restrictions:** The patient is restricted from lifting more than _____lbs, and also cannot: _____.

X (3) **"Housework" or replacement services:** As some housework may involve bending, lifting, twisting, and prolonged standing, i.e. vacuuming, making beds, washing floors, sinks, bathtubs, toilets, moving furniture, picking up objects off floors, child care, carrying garbage or groceries, etc., it is my opinion that the patient cannot do housework from 7/25/12 to 8/25/12.

_____(4) **Attendant Care:** The patient needs help taking care of his/her own personal needs including, but not limited to, dressing using the restroom, supervising, driving to/from doctor appointments, carrying, passing medication, assisting with bathing, lifting, taking care of grooming needs, anything needing patient to bend or twist, feeding, cooking meals, ambulating all general hygiene needs. It is my opinion that the patient needed these services from _____ through _____ for _____ hours a day, _____ days per week.

X (5) **Driving:** The patient is unable to drive and requires transportation services from 7/25/12 through 8/25/12.

X (6) **Recreational Activities:** The patient should not engage or attempt to engage in activities that would aggravate his/her underlying condition by lifting greater than the amount indicated above, excessive bending, twisting, turning, or prolonged standing or sitting, i.e. running, climbing, biking, wrestling, etc.

FAXED

Dr.'s Signature: [signature] Today's Date: 8/21/12

Print Dr.'s Name: Ryan M Lukowski

Elite Health Centers
7700 2nd Avenue Suite 410
Detroit MI, 48202
Phone: 313-986-1100 Fax: 313-338-3082

Disability Certificate

Re: Carrie McDonald (PATIENT NAME) 5/23/12 (DATE OF ACCIDENT)

I have examined and/or treated the above-named patient for injuries sustained in the above accident. As a result of the injuries received in this accident, ***I have disabled and/or restricted the patient from those activities marked with and "X" or the paragraphs with dates imputed:***

_____(1) **Work/Employment Disability:** The patient has been on work disability from _____ through _____.

X (2) **Work Restrictions:** The patient is restricted from lifting more than 20 lbs, and also cannot: bend, sit, stand, twist for prolonged periods

_____(3) **"Housework" or replacement services:** As some housework may involve bending, lifting, twisting, and prolonged standing, i.e. vacuuming, making beds, washing floors, sinks, bathtubs, toilets, moving furniture, picking up objects off floors, child care, carrying garbage or groceries, etc., it is my opinion that the patient cannot do housework from _____ to _____.

_____(4) **Attendant Care:** The patient needs help taking care of his/her own personal needs including, but not limited to, dressing using the restroom, supervising, driving to/from doctor appointments, carrying, passing medication, assisting with bathing, lifting, taking care of grooming needs, anything needing patient to bend or twist, feeding, cooking meals, ambulating all general hygiene needs. It is my opinion that the patient needed these services from _____ through _____ for _____ hours a day, _____ days per week.

X (5) **Driving:** The patient is unable to drive and requires transportation services from 9/10/12 through 9/24/12.

X (6) **Recreational Activities:** The patient should not engage or attempt to engage in activities that would aggravate his/her underlying condition by lifting greater than the amount indicated above, excessive bending, twisting, turning, or prolonged standing or sitting, i.e. running, climbing, biking, wrestling, etc.

Dr.'s Signature: [signature] FAXED Today's Date: 9/10/12

Print Dr.'s Name: Ryan M Lukowski

Elite Health Centers
7700 2nd Avenue Suite 410
Detroit MI, 48202
Phone: 313-986-1100 Fax: 313-338-3082

Disability Certificate

Re: Carrie McDonald (PATIENT NAME) 5/23/12 (DATE OF ACCIDENT)

I have examined and/or treated the above-named patient for injuries sustained in the above accident. As a result of the injuries received in this accident, ***I have disabled and/or restricted the patient from those activities marked with and "X" or the paragraphs with dates imputed:***

X (1) **Work/Employment Disability:** The patient has been on work disability from 10/15/12 through 11/15/12.

____(2) **Work Restrictions:** The patient is restricted from lifting more than ____lbs, and also cannot: ____.

X (3) **"Housework" or replacement services:** As some housework may involve bending, lifting, twisting, and prolonged standing, i.e. vacuuming, making beds, washing floors, sinks, bathtubs, toilets, moving furniture, picking up objects off floors, child care, carrying garbage or groceries, etc., it is my opinion that the patient cannot do housework from 10/16/12 to 11/15/12.

____(4) **Attendant Care:** The patient needs help taking care of his/her own personal needs including, but not limited to, dressing using the restroom, supervising, driving to/from doctor appointments, carrying, passing medication, assisting with bathing, lifting, taking care of grooming needs, anything needing patient to bend or twist, feeding, cooking meals, ambulating all general hygiene needs. It is my opinion that the patient needed these services from ____ through ____ for ____ hours a day, ____ days per week.

X (5) **Driving:** The patient is unable to drive and requires transportation services from 10/15/12 through 11/15/12.

X (6) **Recreational Activities:** The patient should not engage or attempt to engage in activities that would aggravate his/her underlying condition by lifting greater than the amount indicated above, excessive bending, twisting, turning, or prolonged standing or sitting, i.e. running, climbing, biking, wrestling, etc.

Dr.'s Signature: [signature] Today's Date: 10/15/12

Print Dr.'s Name: Dr. Ryan Lukowski

Elite Health Centers, INC.
7700 2nd Ave.
Detroit, MI. 48202
Phone: (313) 986-1100 Fax: (313) 338-3082

Disability Certificate

Re: Carrie McDonald (PATIENT NAME) 5/23/2012 (DATE OF ACCIDENT)

I have examined and/or treated the above-named patient for injuries sustained in the above accident. As a result of the injuries received in this accident, ***I have disabled and/or restricted the patient from those activities marked with and "X" or the paragraphs with dates imputed:***

X (1) **Work/Employment Disability:** The patient has been on work disability from 5/25/12 through 6/25/12.

____ (2) **Work Restrictions:** The patient is restricted from lifting more than ____ lbs, and also cannot: ____.

X (3) **"Housework" or replacement services:** As some housework may involve bending, lifting, twisting, and prolonged standing, i.e. vacuuming, making beds, washing floors, sinks, bathtubs, toilets, moving furniture, picking up objects off floors, child care, carrying garbage or groceries, etc., it is my opinion that the patient cannot do housework from 5/25/12 to 6/25/12.

____ (4) **Attendant Care:** The patient needs help taking care of his/her own personal needs including, but not limited to, dressing using the restroom, supervising, driving to/from doctor appointments, carrying, passing medication, assisting with bathing, lifting, taking care of grooming needs, anything needing patient to bend or twist, feeding, cooking meals, ambulating all general hygiene needs. It is my opinion that the patient needed these services from ____ through ____ for ____ hours a day, ____ days per week.

X (5) **Driving:** The patient is unable to drive and requires transportation services from 5/25/12 through 6/25/12.

X (6) **Recreational Activities:** The patient should not engage or attempt to engage in activities that would aggravate his/her underlying condition by lifting greater than the amount indicated above, excessive bending, twisting, turning, or prolonged standing or sitting, i.e. running, climbing, biking, wrestling, etc.

Dr.'s Signature: [signature] Today's Date: 5/25/12

Print Dr.'s Name: Ryan M Lukowski

Elite Chiropractic, P.C. **Exam**

Patient's Name: Carrie McDonald Date: 5/25/12

Date of Birth: [redacted] 68 Age: 44 Sex: M (F) ☐ MM ☐ WC ☑ NF/PI ☐ MCR ☐ LIEN ☐ CASH

■ HISTORY OF PRESENT CONDITION(S)

Carrie Was Passenger on DOT Bus on 5/25/12
She was sitting in Mid Bus on Driver Side and got
hit on Driver side, ER did nothing
Since then the patient has experience

■ PRIMARY/ASSOCIATED COMPLAINT(S) – Pain rating scale #1 - #10 with #10 being the worst pain

☑ Headache ☑ Right: ☐ Left:
Left 10 Frontal / Temporal
Throbbing

☑ Neck ☑ Right ☑ Pain F ☑ Pain Scale # 9-10 ☐ Numb
☑ Left ☑ Pain F ☑ Pain Scale # ☐ Numb
Pulling Achy Sharp w/ movt

☑ Trapezius ☑ Right ☑ Pain F ☑ Pain Scale # 9-10 ☐ Numb
☑ Left ☑ Pain F ☑ Pain Scale # ☐ Numb
Pulling Achy, Sharp w/ movt

☐ Shoulder ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Elbow ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Wrist ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Hand ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Finger(s) ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb
List Digits:

☑ Mid-Back ☑ Right ☑ Pain F ☑ Pain Scale # 9-10 ☐ Numb
☑ Left ☑ Pain F ☑ Pain Scale # ☐ Numb
Pulling Achy, Sharp w/ movt

☑ low Back ☑ Right ☐ Pain F ☑ Pain Scale # 9 ☐ Numb
☑ Left ☐ Pain F ☑ Pain Scale # ☐ Numb
when laying down, Movt
Sharp, pulling

☑ Buttocks ☑ Right ☐ Pain ☐ Pain Scale # 9 ☐ Numb
☑ Left ☐ Pain ☐ Pain Scale # ☐ Numb
when laying down, Sitting, Movt

☐ Hip ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Knee ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Ankle ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Foot ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb

☐ Toe(s) ☐ Right ☐ Pain ☐ Pain Scale # ☐ Numb
☐ Left ☐ Pain ☐ Pain Scale # ☐ Numb
List Digits:

☐ Weakness ☐ Right: ☐ Left:
☐ UE: ☐ LE:

☐ Coldness ☐ Right: ☐ Left:
☐ UE: ☐ LE:

☐ Burning ☐ Right: ☐ Left:
☐ UE: ☐ LE:

☑ Tingling ☐ Right: ☑ Left: Finger
Numbness ☐ UE: ☐ LE:

☐ Pain Radiating To ☑ Right: Butt
☑ Left:

☐ Other No Sleep Because of Pain

Patient's Name: Carrie McDonald Date: 5/25/12

■ ALLERGIES ☐ No Allergies ☑ Allergic To:

Excema

■ MEDICATION ☑ Patient Denies Taking Any Medication ☐ Medications Taken:

■ REVIEW OF SYSTEMS

■ RESULTS OF PREVIOUS TREATMENT & TESTS PERFORMED ☐ None

ER - Ibuprophen 600mg, Palpation No Tests

■ SOCIAL/FAMILY MEDICAL HISTORY

☐ Heart Disease ☐ Stroke ☐ Circulatory Disorder ☐ Blood Pressure ☐ Diabetes ☐ Other:

■ HISTORY OF PRE-EXISING ILLNESSES

Brain Aneurysm 2008

Excema

■ WORKER'S COMPENSATION QUESTIONS

Date of Injury: _____ Time: _____ AM/PM

Location (City and state where injury occurred): _____

Did patient go to the hospital? ☐ Yes ☐ No Via: ☐ Ambulance ☐ Other: _____

Did patient suffer any cuts or contusions? ☐ No ☐ Yes Describe: _____

Is the patient working at the present time? ☐ Yes ☐ No Date last worked: _____

Has the patient missed any time from work? ☐ Yes ☐ No Dates: _____

At work patient is required to (in hours): Stand:____ Drive:____ Walk:____ Lift:____ Sit: Type:____ Other:_____

What limitations does patient experience as a result of the injury? (Circle Affected Area): Standing Driving Walking Lifting Sitting Typing Other _____ Further describe limitations: _____

■ PERSONAL INJURY QUESTIONS

Date of Injury: 5/23/12 Time: 9:08 AM/PM

Was patient: ☐ Driver ☑ Passenger ☐ Front Seat ☐ Rear Seat ☐ Pedestrian ☑ Other Bus Sitting on the

Was patient wearing seat belt? ☐ Yes ☐ No Did the airbag deploy? ☐ Yes ☐ No

Area of impact: ☐ Front ☑ Rear ☐ Passenger side ☐ Driver Side ☐ Other (Describe): Back of Bus on SIDE

Did patient go to the hospital? ☑ Yes ☐ No Via: ☐ Ambulance ☐ Other (Indicate): _____

Did patient suffer any cuts or contusions? ☐ Yes ☐ No (Describe): _____

X-rays taken? ☐ Yes ☑ No Region(s) _____

Fractures? ☐ Yes ☐ No Region(s)/Location(s) _____

Is the patient working at the present time? ☐ Yes ☑ No Date last worked: Laid OFF

Has the patient missed any time from work? ☐ Yes ☐ No Dates: _____

At work patient is required to (in hours): Stand:___ Drive:___ Walk:___ Lift:___ Sit:___ Type:___ Other:_____

What limitations does patient experience as a result of the injury? (Circle affected area(s) below):

Standing Driving Walking Lifting Sitting Typing Other (Describe): _____

Walking ->5 min Sitting - 20 minutes

Laying Down - immediately No Lifting

Patient's Name: Carrie McDonald Date: 5/25/12

PHYSICAL EXAMINATION – General
Height: _____ Weight: _____ Pulse: _____ BP: _____
Patient is: ☐ Right handed ☐ Left handed

CNS Visual Fields ☐ Normal ☐ Abnormal
Fine Motor ☐ Normal ☐ Abnormal

General Findings
Spasm ☐ Cervical ☐ Thoracic ☐ Lumbar
Tenderness ☐ Cervical ☐ Thoracic ☐ Lumbar
Trigger Points ☐ Cervical ☐ Thoracic ☐ Lumbar

Neck/Traps
Ranges of Motion: *with pain*
Flexion /50
Extension /60
Right Rotation /80
Left Rotation /80
Right Lateral Flexion /45
Left Lateral Flexion /45

Orthoplastic Tests:
Foraminal Compression R L
+ - Spurling's R L
Foraminal Distraction R L
+ - Jackson's R L
Shoulder Depressor R L
+ - Soto Hall R L
+ - Other _____

Thoracic/Upper Trunk
Ranges of Motion: *with pain*
Flexion /60
Right Rotation /30
Left Rotation /30

Orthopedic Tests:
+ - Adams
+ - Soto Hall
+ - Schuppelmann's R L
+ - Forester's
☐ Other _____

+ Lt Lean left Rt Pain
+ Rt " Lt Pain

Lumbar/Lower Trunk
Ranges of Motion: *with pain*
Flexion /90
Extension /25
Left Lateral Bending /25
Right Lateral Bending /25

Orthopedic Tests:
+ - Belt R L
+ - Lasegue/SLR R L
+ - Ely's R L
+ - Kemp's R L
+ - Braggard's R L
+ - Millgram's R L
+ - Double SLR R L
+ - Nachlas R L
+ - Yeoman's R L
+ - Other Rt Pats ↑ Pain to Neck

MUSCLE TESTING 4x5 week

Muscle Strength Rating System: x/5=Muscle Strength 0=Paralysis 1=No Movement/Minor Contraction 2=Movement w/no Gravity 3=Full ROM/Perceptible Weakness 4=Full ROM/Moderate Resistance 5=Full ROM/Maximum Strength

	Deltoid		Triceps		Biceps		Forearm Muscles		Intrinsic Musc/Hand		Quadriceps		Hamstrings		Calf Muscles		Ext Hallicus Longus	
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Muscle Strength	/5	/5	/5	/5	4/5	5/5	/5	/5	/5	/5	/5	/5	/5	/5	/5	/5	/5	/5
Muscle Atrophy	5	5	N	N	N	N	4	5	5	5	5	5	5	—				

Muscle Atrophy Rating System: P=Present A=Absent

DERMATOMES Check all that apply:

	C5		C6		C7		C8		T1		L1		L2		L3		L4		L5		S1	
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Hyperesthesia	✓		✓																			
Hypoesthesia					✓		✓		✓		✓		✓		✓		✓		✓		✓	
Normal		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓

GAIT ☐ Normal ☐ Abnormal ☐ Waddling ☐ Trendelenberg ☐ Antalgic: ☐ Rt ☐ Lt ☐ Forward ☐ Heel Walk _____ ☐ Toe Walk _____

DIAGNOSTIC TESTING ORDERED
ROM
☐ Cervical
☐ Thoracic
☐ Lumbar

CMT
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Sacral
☐

HIGH FREQUENCY TRANSCUTANEOUS NERVE STIMULATION (TCNS)
☐ Spine _____

RADIOLOGY
☐ X-Ray Interp If Taken Elsewhere _____
☐ Spine, Entire (6 view cervical, 2 view thoracic, 4 view lumbar) _____
☐ Spine, Entire (AP&L) _____
☐ Cervical (AP&L) _____
☐ Cervical (min. 4 view) _____
☐ Cervical, Complete (Davis Series) _____
☐ Thoracic (AP&L) _____
☐ Thoracic (Comp. w/ obliques) _____
☐ Thoracic Lumbar (AP&L) _____
☐ Lumbosacral (AP&L) _____
☐ Lumbosacral (Comp. w/ obliques) _____
☐ Lumbosacral (min. 4 views) _____
☐ Pelvis (AP only) _____
☐ Hip, 2 views ☐ Bilateral _____
☐ Other: _____

TREATMENT
☐ Spinal Adjustments
☐ Cold Pack _____ ☐ after exercise/PT
☐ Hot Pack _____ ☐ after exercise/PT
☐ Manual Traction _____
☐ Myofascial Release _____
☐ Neuromuscular Re-Edu _____
☐ Strengthen _____
☐ Stretch/ROM _____
☐ Massage _____
☐ Theraband Exercises _____
☐ UBE (Upper Body Exer.) _____
☐ LBE (Lower Body Exer) _____
☐ Exercise for Instability _____
☐ Gait Training _____
☐ Home Exercise Program _____
☐ Physio Ball Exercises _____
☐ Other _____

Patient's Name: Carrie McDonald Date: 5/25/12

* PROGNOSIS ☑ GUARDED ☐ POOR ☐ GOOD ☐ EXCELLENT

* FREQUENCY OF CARE & TREATMENT GOALS

FREQUENCY: 3 times per week for 12 week then re-evaluate

TREATMENT GOALS: ☐ Decrease Pain ☐ Increase ROM ☐ Decrease Inflammation ☐ Strengthen ☐ Decrease Spasm ☐ Increase Endurance ☐ Improve Gait ☐ Reduce Trigger Points ☐ Increase Flexibility ☐ Sport-specific Strengthening

* SUPPORTS AND DEVICES PRESCRIBED

☐ Cervical Collar ☐ Custom _____
☐ Cervical Traction for Home _____
☐ Cervical Pillow _____
☐ Crutches ☐ Cane _____
☐ Lumbar Support Custom _____
☐ Lumbar Support Elastic Type ☐ w/ magnets _____
☐ Lumbar Seat-Cushion _____
☐ TENS Unit _____
☐ Other: _____

* REFER TO

☐ Orthopedist _____
☑ Neurologist HA, PAIN
☐ Speech/Language Pathologist _____
☐ Chiropractor _____
☐ Other _____

* REFER TO

☑ Physical Therapist Spine
☑ MD PAIN
☐ Massage Therapist _____
☑ MRI HA, PAIN
☐ other _____

Doctor's Name Printed: Ryan M Lukowski Date: 5/25/12

Doctor's Signature: [signature]

3

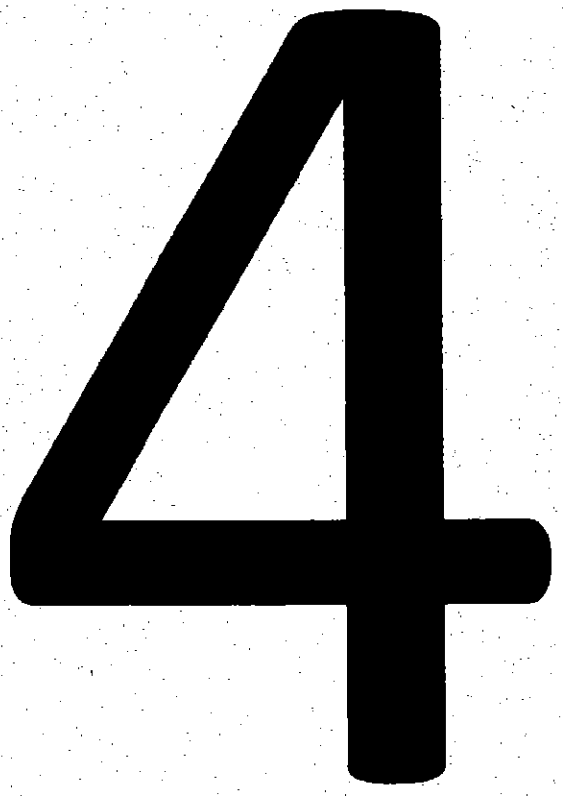
PATIENT NAME: **McDonald, Carrie**
ID: **164667-UPFALL ()**
DOB: [redacted]/68
Exam Date: **05/31/12**

PROBLEM LIST:

CC: Pt chart was reviewed prior to exam. Seen for consultation at the request of Dr. Lukowski. Patient was involved in a traumatic motor vehicle accident, which was the passenger on a bus not wearing a seat belt on May 23, 2012 . Patient did go to the hospital by ambulance after the accident. Patient is complaining of upper, middle, and lower back pain with radiation of the pain down both shoulders and both lower extremities. Patient denies any loss of consciousness and has + headache at this time from the impact of the motor vehicle accident. Patient was not employed as a laborer prior to the accident. Patient is receiving chiropractic manipulation 3 times per week. Patient has a previous medical history of a brain aneurysm A number of years ago.
History: Brain aneurysm
Review of Systems:
Constitutional- unexplained weight changes
Eyes- no visual changes, eye pain
ENMT- no hearing changes
Cardiac- no chest pain, SOB or edema.
Respiratory- no cough or respiratory distress
GI- no nausa, vomiting, adb pain
GU- no dysuria, frequency
Neuro- + headaches or weakness
Msk: Patient complaint upper, middle, and lower back pain with radiation to both shoulders right greater than left as well as the lower extremities bilateral.
Family, Social, History: no alcohol, The patient denies tobacco use, no drugs
44-year-old female. Weight 160 height 5 foot 1 inch. Blood pressure 130/96
Physical Exam: Vital signs are stable.
HEENT- normocephalic, PERRLA, EOM intact thyroid non- palpable
Heart: normal rate,rhythm,and intensity.
Lung: Clear to auscultation bilaterally
Abdomen: Positive bowel sounds, no masses, no bruits, no hernias
Neurologic: Cranial nerves 2-12 intact, motor, sensory, vibratory
Ext: ROM in all four extremities, distal pulses are normal
Skin: normal for age and race
Msk-, bilateral paravertebral muscle spasm noted in the cervical spine region. Decreased range of motion in flexion, extension, lateral side bending bilaterally to active and passive motion testing. Patient has bilateral trapezius point tenderness in the right greater than left. Bilateral paravertebral muscle spasm. The thoracolumbar spine region. Decreased range of motion in flexion, extension, lateral side bending right greater than left to active and passive motion testing. gait is normal, the deep tendon reflexes are symmetrical and equal. Sensory testing was normal
Plan: Pt will continue care with referring/treating doctor 3 times per week
Further testing ordered: MRI of the cervical, thoracic, and lumbar spine region . MRI of the brain due to the headaches
Meds: Flexeril 10 mg, one at bedtime
Return to office in 4 weeks.
impresssions: Traumatic brain, injury. We'll get MRI of the brain history of brain aneurysm
1. cervical myositis/sprain, rule out cervical disc MRI ordered.
2. thoracic myositis-sprain, rule out thoracic disc MRI ordered.
3. lumbar myositis/sprain, rule out lumbar disc MRI ordered.
Patient is not to return to employment at time and not to perform household chores which would include food preparation, dusting, cleaning, vacuuming, as well as out door chores until further notice
Noei Upfall D.O.

ORIGINAL

electronically signed by: , 05/31/12 McDonald, Carrie / 164667



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Date:	September 7, 2012
PATIENT:	CARRIE MCDONALD
DOB:	[redacted]1968
ACCOUNT#:	[redacted]
REF PHYSICIAN:	UPFALL
EXAM:	CT L SPINE

History: Low back pain after a motor vehicle accident.

Procedure: CT imaging through the lumbar spine was performed in the axial plane. 3-mm thick slices were reviewed with bone and soft tissue windows. Sagittal and coronal two-dimensional and 3-dimensional reconstructions were created.

Findings: The lumbar vertebra are normal in height and density. There is no fracture or bony destructive lesion.

There is no paraspinous soft tissue mass.

There is minimal atherosclerosis of the aorta.

At T12-L1 through L2-3 the disks are normal in height. There is no focal disk displacement or herniation. The canal and foramina are patent.

At L3-4 there is normal disk space heights. There is mild disk displacement. The canal diameter is adequate. The foramina are patent.

At L4-5 there is normal disk space height. There is mild disk displacement without canal or foraminal stenosis.

At L5-S1 there is disk space narrowing. There is grade 1 retrolisthesis. There is mild diffuse disk displacement. The canal diameter is adequate. There is mild bilateral foraminal stenosis.

IMPRESSION: DISK DISPLACEMENT AT L3-4 THROUGH L5-S1.

GRADE 1 RETROLISTHESIS AND DISK SPACE NARROWING AT L5-S1.

MINIMAL ATHEROSCLEROSIS OF THE AORTA.

Electronically Approved By Michael J. Paley, MD 2012-9-10 14:44

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Date:	September 7, 2012
PATIENT:	CARRIE MCDONALD
DOB:	[redacted]1968
ACCOUNT#:	[redacted]
REF PHYSICIAN:	
EXAM:	CT LOWER EXT\CT RT HIP

History: Right hip pain after a motor vehicle accident

Procedure: CT imaging through the right hip was performed and an eye. 2-mm thick slices were reviewed in bone and soft tissue windows. Coronal and sagittal two-dimensional reconstructions were created and reviewed as well.

Findings: There is no fracture, dislocation or other acute appearing bony abnormality.

Bony mineralization is satisfactory.

There is subtle subchondral cystic change of the supralateral aspect of the acetabulum. There is no significant joint space narrowing or bony spurring.

The muscular structures appear normal in density and configuration. There is no evidence for muscle mass or hematoma. The hamstring tendon origin is grossly intact.

There is no space-occupying mass or fluid collection.

There are no enlarged inguinal lymph nodes. There is no evidence for an inguinal hernia.

The visualized portions of the urinary bladder appear normal. There are scattered phleboliths in the pelvis.

IMPRESSION: MILD SUBCHONDRAL CYSTIC CHANGES OF THE SUPRALATERAL ASPECT OF THE ACETABULUM.

Electronically Approved By Michael J. Paley, MD 2012-9-10 14:56

5

MCDONALD, CARRIE- [redacted]
[redacted] 1984 4/16/13
DATE OF PROCEDURE/SURGERY: PROCEDURE NOTE

RE:

PREOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1
2. Lumbar spondylosis.
3. Facet syndrome.

POSTOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1
2. Lumbar spondylosis.
3. Facet syndrome.

OPERATIVE PROCEDURE:
1. Epidural steroid injection, L5-S1
2. Epidurogram.
3. Fluoroscopy.
4. Bilateral facet injections at L4-5
5. Bilateral facet injections at L5-S1

SURGEON: Louis N. Radden, D.O.

ANESTHESIA: 1% Xylocaine, 0.25% Marcaine with epinephrine, 80 mg. of Depo-Medrol.

OPERATIVE PROCEDURE IN DETAIL: The patient was placed in the prone position. The back was prepped and draped under usual surgical technique. Under fluoroscopic control, the appropriate disc space was identified. The area was infiltrated with 1% Xylocaine. Once again under fluoroscopic control, the Touphy needle was then easily inserted into the epidural space. This was confirmed by the loss-of-resistance technique. After this, approximately 1 cc of Isovue was then injected into the epidural space. The dye flowed freely along the nerve roots without obstruction. Following this, 80 mg. of Depo-Medrol and 2 cc of saline and 1 cc of 0.25% Marcaine with epinephrine were injected into the epidural space. Once this was complete, the Touphy needle was then easily inserted into the bilateral facet joints at L4-5. Once this was complete, 80 mg. of Depo-Medrol and 1 cc of 0.25% Marcaine with epinephrine were injected into the bilateral facet joints at L4-5. The previous sequence of events was repeated with the bilateral facet joint injections at L5-S1.

The patient tolerated the procedure well and remained neurologically stable.

Louis N. Radden, D.O.

LNR/cjm

MCDONALD, CARRIE [redacted]
[redacted]1968
[redacted]1013 9-13-13
DATE OF PROCEDURE/SURGERY

PROCEDURE NOTE

PREOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1.
2. Lumbar spondylosis.
3. Facet syndrome.

POSTOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1.
2. Lumbar spondylosis.
3. Facet syndrome.

OPERATIVE PROCEDURE:
1. Epidural steroid injection, L5-S1.
2. Epidurogram.
3. Fluoroscopy.
4. Bilateral facet injections at L4-5.
5. Bilateral facet injections at L5-S1.

SURGEON: Louis N. Redden, D.O.

ANESTHESIA: 1% Xylocaine, 0.25% Marcaine with epinephrine, 80 mg. of Depo-Medrol.

OPERATIVE PROCEDURE IN DETAIL: The patient was placed in the prone position. The back was prepped and draped under usual surgical technique. Under fluoroscopic control, the appropriate disc space was identified. The area was infiltrated with 1% Xylocaine. Once again under fluoroscopic control, the Touphy needle was then easily inserted into the epidural space. This was confirmed by the loss-of-resistance technique. After this, approximately 1 cc of Isovue was then injected into the epidural space. The dye flowed freely along the nerve roots without obstruction. Following this, 80 mg. of Depo-Medrol and 2 cc of saline and 1 cc of 0.25% Marcaine with epinephrine were injected into the epidural space. Once this was complete, the Touphy needle was then easily inserted into the bilateral facet joints at L4-5. Once this was complete, 60 mg. of Depo-Medrol and 1 cc of 0.25% Marcaine with epinephrine were injected into the bilateral facet joints at L4-5. The previous sequence of events was repeated with the bilateral facet joint injections at L5-S1.

The patient tolerated the procedure well and remained neurologically stable.

Louis N. Redden, D.O.

MCDONALD, CARRIE [redacted]
[redacted]1968
[redacted]1013 2/13/13
DATE OF PROCEDURE/SURGERY

EPIDUROGRAM

PREOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1
2. Lumbar spondylosis.

POSTOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1
2. Lumbar spondylosis.

OPERATIVE PROCEDURE:
1. Epidurogram.
2. Fluoroscopy.

SURGEON: Louis N. Radden, D.O.

ANESTHESIA: 1% Xylocaine, 0.25% Marcaine with epinephrine, 80 mg. of Depo-Medrol.

OPERATIVE PROCEDURE IN DETAIL: The patient was placed in the prone position. The back was prepped and draped under usual surgical technique. Under fluoroscopic control, the appropriate disc space was identified. The area was infiltrated with 1% Xylocaine. Once again under fluoroscopic control, the Touphy needle was then easily inserted into the epidural space. This was confirmed by the loss-of-resistance technique. After this, approximately 1 cc of Isovue was then injected into the epidural space. The dye flowed freely along the nerve roots without obstruction. There were no signs of scarring.

The patient tolerated the procedure well and remained neurologically stable.

Louis N. Radden, D.O.

LNR/cjm

Epidurogram.L2013

MCDONALD, CARRIE [redacted]
[redacted]1968
[redacted]1013 3-13-13
DATE OF PROCEDURE/SURGERY

PROCEDURE NOTE

PREOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1.
2. Lumbar spondylosis.
3. Facet syndrome.

POSTOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1.
2. Lumbar spondylosis.
3. Facet syndrome.

OPERATIVE PROCEDURE:
1. Epidural steroid injection, L5-S1.
2. Epidurogram.
3. Fluoroscopy.
4. Bilateral facet injections at L4-5.
5. Bilateral facet injections at L5-S1.

SURGEON: Louis N. Radden, D.O.

ANESTHESIA: 1% Xylocaine, 0.25% Marcaine with epinephrine, 80 mg. of Depo-Medrol.

OPERATIVE PROCEDURE IN DETAIL: The patient was placed in the prone position. The back was prepped and draped under usual surgical technique. Under fluoroscopic control, the appropriate disc space was identified. The area was infiltrated with 1% Xylocaine. Once again under fluoroscopic control, the Touhy needle was then easily inserted into the epidural space. This was confirmed by the loss-of-resistance technique. After this, approximately 1 cc of Isovue was then injected into the epidural space. The dye flowed freely along the nerve roots without obstruction. Following this, 80 mg. of Depo-Medrol and 2 cc of saline and 1 cc of 0.25% Marcaine with epinephrine were injected into the epidural space. Once this was complete, the Touhy needle was then easily inserted into the bilateral facet joints at L4-5. Once this was complete, 80 mg. of Depo-Medrol and 1 cc of 0.25% Marcaine with epinephrine were injected into the bilateral facet joints at L4-5. The previous sequence of events was repeated with the bilateral facet joint injections at L5-S1.

The patient tolerated the procedure well and remained neurologically stable.

Louis N. Radden, D.O.

MCDONALD, CARRIE [redacted]
[redacted]1958
[redacted]1013 3/13/13
DATE OF PROCEDURE/SURGERY

EPIDUROGRAM

PREOPERATIVE DIAGNOSES:
1. Lumbar disc herniation, L5-S1
2. Lumbar spondylosis.

POSTOPERATIVE DIAGNOSES: L5-S1
1. Lumbar disc herniation,
2. Lumbar spondylosis.

OPERATIVE PROCEDURE:
1. Epidurogram.
2. Fluoroscopy.

SURGEON: Louis N. Redden, D.O.

ANESTHESIA: 1% Xylocaine, 0.25% Marcaine with epinephrine, 80 mg. of Depo-Medrol.

OPERATIVE PROCEDURE IN DETAIL: The patient was placed in the prone position. The back was prepped and draped under usual surgical technique. Under fluoroscopic control, the appropriate disc space was identified. The area was infiltrated with 1% Xylocaine. Once again under fluoroscopic control, the Touphy needle was then easily inserted into the epidural space. This was confirmed by the loss-of-resistance technique. After this, approximately 1 cc of isovue was then injected into the epidural space. The dye flowed freely along the nerve roots without obstruction. There were no signs of scarring.

The patient tolerated the procedure well and remained neurologically stable.

Louis N. Redden, D.O.

LNR/cjm

Epidurogram-L2953

6

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www.independentevalservices.com

September 13, 2012

RE: Carrie McDonald
DOB: [redacted]/68
Claim#: [redacted]2697
D/I: 5/23/12

I saw Carrie McDonald for an independent orthopedic evaluation on September 13, 2012 in Southfield, Michigan. This evaluation did not constitute a physician/patient relationship, and I informed her that no treatment would be rendered by me.

SYMPTOMS

Arriving at the clinic today Ms. McDonald stated she was feeling good. She continues to have bilateral aching temple pain. Vision is blurry, she thinks due to use of over the counter glasses. She has low back pain extending to her hips without weakness in the upper or lower extremities. Standing exacerbates the back pain and some relief is attributed to chiropractic manipulation.

HISTORY OF PRESENT ILLNESS

At 9:30 am on May 23, 2012, Ms. McDonald was seated on a Detroit City Bus that was struck from behind by a truck, causing many passengers to fall from their seats. The driver seemed to be alternating pressing the accelerator and the brake, causing Ms. McDonald to be jerked back and forth striking the window, without lacerating her scalp and not throwing her to the floor. She did not lose consciousness, but had severe headaches afterward. She was taken to Receiving Hospital by ambulance where she was observed for three hours and released without x-ray studies. At home a neighbor advised she contact a lawyer who suggested follow-up with Dr. Upfall. She had some x-ray studies without identifying a fracture but a CT scan showed a blood clot "on my brain". Last Friday she had percutaneous placement of a coil in a cerebral artery.

Pertinent past history includes in 2008 for a cerebral aneurysm that was treated surgically by a coil.

She has been going to a chiropractor 3 times per week, recently decreased to 2 times per week for back pain. Physical therapy is scheduled to start next week.

MEDICATIONS

She is on the anticoagulant Plavix and takes aspirin.

PAST MEDICAL HISTORY

She denies a history of trauma, surgery (other than noted above), diabetes, arthritis or endocrine conditions. Review of systems is negative for strokes, seizures, epilepsy, migraines, ataxia, diplopia, numbness or weakness. The remainder of the review is unremarkable.

OCCUPATIONAL HISTORY

Ms. McDonald was on her way to her job as a clerk when she was on the bus and has been laid off. She is actively seeking work.

SOCIAL HISTORY

She abstains from smoking and alcohol use. She was educated through the 10th grade of high school, but then has pursued an associate's degree in computers at Wayne County Community College, but is not currently enrolled. Past hobby was swimming. She has no childcare responsibilities.

PHYSICAL EXAMINATION

Ms. McDonald is an overweight woman whose height is 5'2" and weight is 209 pounds. She ambulates with a normal gait without limping. She was not unable to perform a squat nor

could she walk on her heels or toes, likely due to her body habitus. She did not appear in pain. Spinal curvatures were normal.

Examination showed her head to be normocephalic and atraumatic. Cranial nerves II through XII were intact. Visual fields are full. PERRLA and EOM intact. She moves all extremities without difficulty. Her pinch strength was 9 pounds on the right and 5 pounds on the left. She has no sign of spasticity. Deep tendon reflexes are 3+ in the upper extremities, absent in the knees, and ankles. Straight leg raising is negative bilaterally. There is no tenderness to palpation of the lumbar spine. There is no sign of symptom magnification.

Her speech is fluent, memory is quick without any scanning. Her mood seemed upbeat. Rhomboid tests were negative and she can do tandem walking effectively.

RECORD REVIEW

No records were available.

IMPRESSION

Ms. McDonald sustained trauma in a bus/truck accident in May 2012 and was not seen until later after she developed severe headaches and was found to have an intracranial bleed, likely from a coup-contrecoup force on the brain resulting in swinging of the brain inside the cranium, causing an aneurysm to bleed. She had a previous coil placed for an aneurysm in 2008. Last Friday, she was treated by the percutaneous placement of another coil, she said.

Subsequently, she has been recovering, but still has intermittent headaches and is restricted post-operatively by her attending physician, who intends to see her next week. Ms. McDonald is motivated to return to work when released.

Based on her history, she sustained an intracranial bleed as the result of the motor vehicle accident. Examination does not show any neurological sequelae and the prognosis for full recovery is good.

RECOMMENDATION

It is recommended that she receive physical therapy addressed to her low back complaints. There were no signs of nerve root impingement and she is uncertain whether the studies showed disc injury from the accident. Based on examination findings alone, it appears that she has a soft tissue strain of her back that should resolve with further physical therapy.

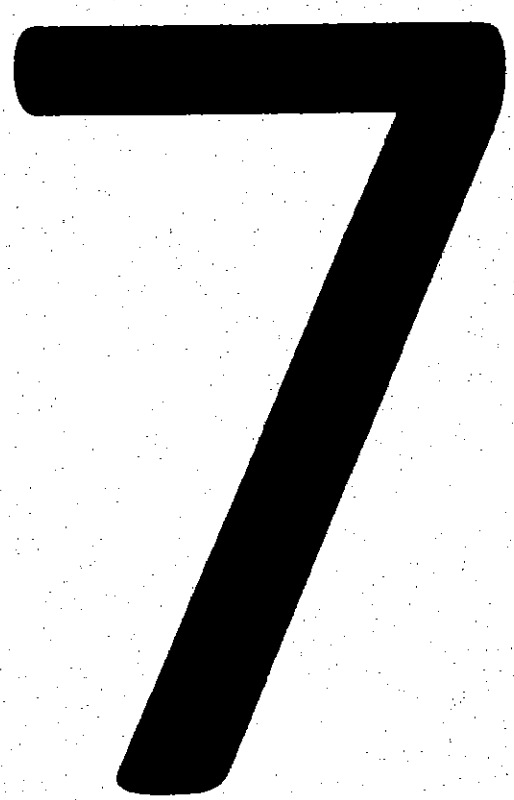
Thank you for the opportunity of evaluating this individual. If you have any questions, please do not hesitate to contact me at Independent Evaluation Services.

Sincerely,

Richard Ilka, M.D.

Richard A. Ilka, M.D., M.P.H.
Board Certified Occupational & Environmental Medicine
Consultant to Independent Evaluation Services

RAI/amn



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www.independentevalservices.com

February 26, 2013

RE: Carrie McDonald
DOB: [redacted]1968
Claim#: [redacted]2697
D/I: 05/23/2012

Today, February 26, 2013, I had the opportunity to perform an independent medical evaluation on Ms. Carrie McDonald at your request. Allegations include headaches, neck pain, back pain, bilateral shoulder and hip pain.

Before we began, Ms. McDonald was informed that this was an evaluation only and no treatment would be rendered.

HISTORY OF PRESENT COMPLAINT

Ms. McDonald is a 45-year-old, right-handed female who was involved in a bus accident on May 23, 2012. She states she was sitting on the left side of the bus when the bus was rear-ended. This caused the driver to initially hit the gas and then to brake. With these movements, Ms. McDonald reports that she fell out of her seat and then back into it. She denies hitting her head or losing consciousness. She was having some back and neck pain, as well as dizziness. Police and EMS came and she was taken to Receiving Hospital. She states at Receiving Hospital, she was given some pain pills, which she believes were Naproxen and sent home.

Over the next week, it appears she obtained services of an attorney and also started treatment with Dr. Ryan at Elite Chiropractic for treatment. She also saw Dr. Upfall who may be affiliated with Elite Chiropractic, as well. About a month after the accident, she also saw her primary care physician, Dr. Yanez, for regular follow up and for the back pain. With regards to the back, he implemented no treatment.

She continues to follow up with Dr. Ryan for chiropractic treatments, at this time seeing him approximately two times a month. She reports that when she is doing the treatment, she does feel better, though she has minimal long lasting relief. Approximately one to two months after the accident, she did start physical therapy, though this was stopped secondary to brain surgery. She does feel that therapy was helping.

She does follow up with Dr. Upfall, who she saw approximately a month ago. He was prescribing medications and did order some CT scans of the neck, back and hips though she is uncertain of the results. He has also referred her to a pain specialist, Dr. Raden, approximately two to three months ago. It appears that Dr. Raden is writing for her Vicodin at this time. He is also performing what appear to be lumbar epidural injections. She has completed two injections and has one more pending. She feels they help a little bit, but they do not last long.

Since her accident, she has had a brain aneurysm repaired this past August. She also had a previous brain aneurysm repaired in 2008.

She denied any history of back or neck pain or previous motor vehicle accidents.

CURRENT COMPLAINTS

She is currently complaining of neck and back pain that radiates into the left greater than right hip. Her main problem is the back and hip pain.

She states the back pain is located more in the center and is described as an aching. She notes it is hard for her to stand up, but when she is up, the pain does seem to ease up. Pain overall is worse with transition movements, in the morning, and if she is in one position too long, as well as when it rains. Symptoms are better with moving around and with changing her position. She denies any numbness or tingling down the legs, though she does have occasional pain in the left lateral thigh that just comes and goes.

With regards to the neck pain, this comes and goes. It is located mainly in the middle of the neck over the "spine bone". She describes this as a pressure to a tightness and soreness. This neck pain can be worse with looking down too long and better if she straightens the neck and does some exercises a little bit. She denies any radiation of symptoms down the upper extremities; no numbness or tingling.

She states that with her treatment, her neck pain has improved approximately 15 to 20 percent and her back approximately 10 percent.

PAST MEDICAL HISTORY

Negative.

PAST SURGICAL HISTORY

Brain aneurysm, status-post coiling in 2008 and 2012.

MEDICATIONS

Vicodin approximately 4 per day. She has been taking this for approximately two months as prescribed by Dr. Raden.

ALLERGIES

No known drug allergies.

SOCIAL HISTORY

She is single. She does not smoke or drink. When asked about her history, she states she does not want to answer these questions.

WORK HISTORY

Her last date of work was April 26, 2011. At that time, she worked for a cook at C.F. & G. Enterprise.

REVIEW OF SYSTEMS

Review of systems is positive for weight gain, night sweats, headaches, back and neck pain, difficulty reading with occasional blurred vision, occasional weakness in the arm and leg, intermittent constipation, occasional forgetfulness. All other systems reviewed were negative.

PHYSICAL EXAMINATION

Height: 5'1". Weight: 219 pounds. Movements on and off the examination table are fluid. Gait is non-antalgic with a normal heel strike. Patient is able to walk on her heels, but is unable to walk on her toes or to squat.

With examination of the cervical spine, patient reports diffuse tenderness to palpation in the midline and bilateral paraspinals. She has decreased extension and rotation with increased pain most notably with extension. She does hold her neck in a slightly protruded position.

On examination of the lumbar spine, she reports tenderness to palpation in the midline and bilateral paraspinals from L5 through the sacrum. Range of motion with flexion is limited to less than 30 degrees. Extension and side bending is within functional limits. There is increased pain with flexion. Patient does have an exaggerated lordosis in a standing position. Straight leg raise, seated and supine, are negative. There is no palpable shelf or step-off. With Patrick's on the right, she complains of groin pain. With Patrick's on the left, she complains of lateral hip pain.

She has full range of motion of her shoulder, elbow, wrist, hip, knee and ankle. No edema, erythema or increased warmth is noted of any joint. With left hip internal and external rotation, she does complain of left lateral thigh pain. With examination of the shoulder, impingement signs and empty can testing are negative.

Cranial nerves II through XII are intact. Sensation to light touch and pinprick is intact in the bilateral upper and lower extremities. Strength is 5/5 in the bilateral upper and lower extremities. Reflexes are 2+ in the bilateral upper extremities and decreased in the bilateral lower extremities. Hoffman and Babinski are negative.

Patient has normal pulses. No significant edema in the lower extremities. No calf tenderness to palpation. Patient has a scar in the right forearm and in the right knee.

RECORD REVIEW

There is an IME done at Independent Evaluation Services by Dr. Richard Ilka, M.D., Board Certified Occupational and Environmental Medicine. This documents a patient who is having bilateral aching temple pain with blurred vision, which the patient thought was due to use of over-the-counter glasses. She also had low back pain extending to the hips with some relief attributed to the chiropractor. Patient was involved in a Detroit City bus accident on 5/23/12. She was treated at Receiving Hospital and discharged. A neighbor advised she contact a lawyer who suggested she follow up with Dr. Upfall. She had x-rays without identifying a fracture, but a CT scan showed a blood clot on her brain and she had a percutaneous placement of a coil in the cerebral artery the week prior to the exam. She also was noted to have a previous cerebral aneurysm treated in 2008. Patient impression was Coup-countrecoup force in the brain causing her aneurysm to bleed. She still had intermittent headaches and was restricted by her attending physician who she was to follow up with the next week. On exam, there was no neurological sequelae and prognosis for full recovery is good. It was recommended that she receive physical therapy to address her low back complaints. There were no signs of nerve root impingement.

IME from IES by Dr. Alex Steinbock on 10/19/12 was reviewed. Patient is a 44-year-old female who presents for neck and back pain status-post accident. It was noted that she had a coiling for her aneurysm on August 30 and has had frequent headaches since. Symptoms are worse with head movement. It is noted that she goes to a chiropractor monthly and physical therapy three times per week and is currently taking pain medication. Diagnosis was post-traumatic cephalgia, cervical strain, and lumbar strain. There were no objective neurological deficits on examination. There is no evidence of radiculopathy. Prognosis for function and recovery is good. It was noted that her current complaints are primarily musculoskeletal and that she should have recovered from these injuries.

Note from Dr. Noel Upfall dated 11/8/12 is reviewed. This notes the patient had brain surgery on 8/30 at Harper. Patient was a bus passenger not wearing a seat belt on 5/23/12. She was complaining of upper, middle and lower back pain with radiation of the pain down both shoulders and both lower extremities. She denies loss of consciousness though she does have a headache. She continues to see her spine specialist for pain management. He

notes that she may be having an arthrogram of her shoulder recommended by an orthopedic specialist. Patient with complaint of upper, middle and lower back pain. Patient with decreased range of motion in the right hip and the shoulders with pain above 45 degrees. Patient is diagnosed with cervical myositis/sprain, thoracic myositis/sprain, lumbar myositis/sprain. Patient is not to return to employment at that time and not to perform household chores which would include food preparation, dusting, cleaning, vacuuming, as well as outdoor chores until further notice.

Records from Elite Health Center as documenting work-employment disability dated 8/21/12 and 5/25/12 and 6/25/12 are reviewed.

Physical therapy note of 9/24/12 is reviewed.

IMPRESSION

After completing a comprehensive history and physical examination, as well as reviewing the above submitted medical records, based on the information available to me today, it is my opinion that Ms. McDonald suffered a cervical and lumbar strain/sprain. It appears that secondary to the force of the injury, she may have had a coup-countrecoup force causing her aneurysm to bleed for which she has had a coiling. It appears that she was having headaches initially, but those seem to have resolved at this time.

At this time, patient is complaining of neck and back pain with reported tenderness to palpation and decreased range of motion. Neurological exam is essentially normal at this time.

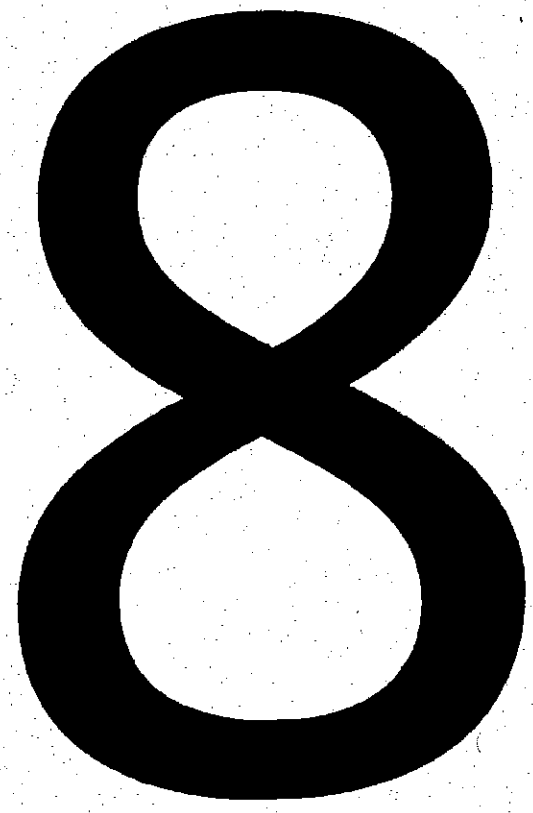
At this time, patient should be able to return to full duty as long as she has been released by her neurosurgeon. I would expect the patient to be at maximal medical improvement with treatment with regards to her back and neck pain. At this time, patient does not appear to be in need of any attendant services.

Thank you for the opportunity of evaluating this individual. If you have any questions, please do not hesitate to contact me at Independent Evaluation Services.

Sincerely,

Christopher Schoenherr, M.D. PM&R

CS/amn



MICHIGAN CENTER FOR PHYSICAL T

INDIVIDUAL PATIENT DETAIL REPORT

Printed on02/05/2014 Wednesday 12:59:43

Date From To 02/05/2014

General Information

Name MCDONALD, CARRIE		Acct# [redacted]		Phone [redacted]	Cash Bal 0.00
Title	DR 01	Ref	Marital Unknown	SSN	Work	Ins Bal 4,350.00
Address [redacted]					Birthday [redacted]1968
Alert COD BANKRUPTCY					First Visit 09/25/2012
Note FROM BITTNER					Last Date 12/17/2012

Policy Information

Financial Code AA	Ins CodeCOD	Insured's Name MCDONALD, CARRIE	Relation Self
ID No# [redacted]2697	Group Number	Phone [redacted]	Participate Yes
Address [redacted]			Assignment Yes

INS Name & Address
CITY OF DETROIT LAW DEPT. , 2 WOODWARD AVENUE , DETROIT, MI 48226

Diagnosis Information: 7245 / 7291 /

Transactions

Claim No	Service Date	Proc Code	DX	DR	Service Charge	Expect Ins	Pat Charge	Cash Paid	Ins Paid	Participat Adjust	Adjust	Balance Cash	Balance Ins	RefID
13957	09/24/2012	97001	7245	04	150.00	150.00	0.00	0.00	0.00	0.00	0.00	0.00	150.00	85241
14141	10/05/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	86574
14141	10/05/2012	97032	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	86575
14141	10/05/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	86576
14141	10/05/2012	97110	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	86577
14141	10/05/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	86578
14206	10/10/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87052
14206	10/10/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87053
14206	10/10/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87054
14206	10/10/2012	97110	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87055
14206	10/10/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87056
14324	10/17/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87763
14324	10/17/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87764
14324	10/17/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87765
14324	10/17/2012	97110	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87766
14324	10/17/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	87767
14382	10/19/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	88198
14382	10/19/2012	97110	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	88199
14382	10/19/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	88200
14458	10/24/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	88590
14458	10/24/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	88591
14458	10/24/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	88592
14458	10/24/2012	97110	7245	04	140.00	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00	88593
14458	10/24/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	88594
14588	10/31/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	89495

Claim No	Service Date	Proc Code	DX	DR	Service Charge	Expect Ins	Pat Charge	Cash Paid	Ins Paid	Participat Adjust	Adjust	Balance Cash	Balance Ins	RefID
14588	10/31/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	89496
14588	10/31/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	89497
14588	10/31/2012	97110	7245	04	140.00	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00	89498
14588	10/31/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	89499
14675	11/05/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90021
14675	11/05/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90022
14675	11/05/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90023
14675	11/05/2012	97110	7245	04	140.00	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00	90024
14675	11/05/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90025
14783	11/12/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90682
14783	11/12/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90683
14783	11/12/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90684
14783	11/12/2012	97110	7245	04	140.00	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00	90685
14783	11/12/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	90686
14848	11/14/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91091
14848	11/14/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91092
14848	11/14/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91093
14848	11/14/2012	97110	7245	04	140.00	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00	91094
14848	11/14/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91095
14970	11/21/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91852
14970	11/21/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91853
14970	11/21/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91854
14970	11/21/2012	97110	7245	04	140.00	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00	91855
14970	11/21/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	91856
15127	12/03/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	92910
15127	12/03/2012	97035	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	92911
15127	12/03/2012	97014	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	92912
15127	12/03/2012	97110	7245	04	140.00	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00	92913
15127	12/03/2012	97140	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	0.00	0.00	70.00	92914
15374	12/17/2012	97010	7245	04	70.00	70.00	0.00	0.00	0.00	0.00	-70.00	0.00	0.00	94444
15374	12/17/2012	97035	7245	04	70.00	70.00	0.00	0.00	51.68	18.32	0.00	0.00	0.00	94445
15374	12/17/2012	97014	7245	04	70.00	70.00	0.00	0.00	44.52	25.48	0.00	0.00	0.00	94446
15374	12/17/2012	97110	7245	04	140.00	140.00	0.00	0.00	140.00	0.00	0.00	0.00	0.00	94447
15374	12/17/2012	97140	7245	04	70.00	70.00	0.00	0.00	54.09	15.91	0.00	0.00	0.00	94448
15374	07/05/2013	INSPAY	7245		0.00	0.00	0.00	0.00	150.29	0.00	0.00	0.00	0.00	116888
15374	07/05/2013	PARADJ	7245		0.00	0.00	0.00	0.00	0.00	0.00	59.71	0.00	0.00	116889
15374	07/05/2013	INSCRE	7245		0.00	0.00	0.00	0.00	0.00	0.00	70.00	0.00	0.00	116890
15374	07/05/2013	INSPAY	7245		0.00	0.00	0.00	0.00	140.00	0.00	0.00	0.00	0.00	116891

Note: DX - Diagnosis
DR - Doctor

MAKE CHECKS PAYABLE TO:

RONALD S LEDERMAN MD PLLC
PO BOX 638027
CINCINNATI OH 45263-8027
248-889-4580

EIN# 010760039

IF PAYING BY CREDIT CARD,FILL OUT BELOW,CHECK CARD USED.

☐ MASTERCARD ☐ VISA

CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/05/2014	3530 33	

[redacted]

CARRIE MCDONALD

[redacted]

RONALD S LEDERMAN MD PLLC
PO BOX 638027
CINCINNATI OH 45263-8027
248-889-4580

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PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY	
			INSURANCE	PATIENT
	CARRIE MCDONALD			
	Date	Statement from 01/01/2000 to 02/05/2014		
04/02/2013	99203	OFFICE VISIT, NEW PT; MODERATE		450.00
04/02/2013	76942	ULTRASOUND GUIDE FOR NEEDLE PLACEMENT		500.00
04/02/2013	20610	INJECTION, LARGE JOINT (KNEE/HIP/SHOULDR		300.00
04/02/2013	J3301	KENALOG INJECTION, 10 MG		140.00
04/02/2013	73520	X-RAY; HIPS, BILATERAL, MIN 2 VIEWS		180.00

BALANCE 1570.00 | 0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT

BILLING QUESTIONS PLEASE CALL (248) 889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
33-3530
CARRIE

MAKE CHECKS PAYABLE TO: RONALD S LEDERMAN MD PLLC
PO BOX 638027
CINCINNATI OH 45263-8027

MAKE CHECKS PAYABLE TO:

ELITE HEALTH CENTERS INC
13927 PLUMBROOK ROAD
STERLING HEIGHTS MI 48312-1727
248-889-4580

EIN# 900748329

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CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/05/2014	2430 23	

CARRIE MCDONALD
[redacted]

ELITE HEALTH CENTERS INC
13927 PLUMBROOK ROAD
STERLING HEIGHTS MI 48312-1727
248-889-4580

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DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD			
05/31/2012		99204 OFFICE VISIT NEW PATIENT EXTENSIVE	250.00	
02/14/2013		INSURANCE PAYMENT	-216.40	
02/14/2013		PARTICIPATING ADJUSTMENT	-33.60	
06/28/2012		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	
02/14/2013		INSURANCE PAYMENT	-136.85	
02/14/2013		PARTICIPATING ADJUSTMENT	-63.15	
08/16/2012		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	
02/14/2013		INSURANCE PAYMENT	-145.55	
02/14/2013		PARTICIPATING ADJUSTMENT	-54.45	
09/20/2012		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	
07/18/2013		INSURANCE PAYMENT	-144.75	
07/18/2013		PARTICIPATING ADJUSTMENT	-55.25	
11/08/2012		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	
04/25/2013		INSURANCE PAYMENT	-144.75	
04/25/2013		PARTICIPATING ADJUSTMENT	-55.25	
12/20/2012		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	
02/07/2013		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	
04/04/2013		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	
		BALANCE	800.00	0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT.

BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
23-2430
CARRIE

MAKE CHECKS PAYABLE TO: ELITE HEALTH CENTERS INC
13927 PLUMBROOK ROAD
STERLING HEIGHTS MI 48312-1727

MAKE CHECKS PAYABLE TO:

ELITE HEALTH CENTERS INC
13927 PLUMBROOK ROAD
STERLING HEIGHTS MI 48312-1727
248-889-4580

EIN# 900748329

[redacted]

CARRIE MCDONALD
[redacted]

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CARD NUMBER **AMOUNT**

SIGNATURE **EXP.DATE**

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/05/2014	2430 23	

[redacted]

ELITE HEALTH CENTERS INC
13927 PLUMBROOK ROAD
STERLING HEIGHTS MI 48312-1727
248-889-4580

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PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	ACCOUNT ACTIVITY PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
06/27/2013		99214 OFFICE VISIT ESTABLISHED PT EXTENSIVE	200.00	

BALANCE	800.00	0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT.

BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
23-2430
CARRIE

MAKE CHECKS PAYABLE TO: ELITE HEALTH CENTERS INC
13927 PLUMBROOK ROAD
STERLING HEIGHTS MI 48312-1727

MAKE CHECKS PAYABLE TO:

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
248-889-4580

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☐ MASTERCARD ☐ VISA

CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/05/2014	1910 21	

[redacted]

CARRIE MCDONALD

[redacted]

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
248-889-4580

☐ Please check if address or insurance has changed. Make changes on reverse side.

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD			
05/25/2012		99205 OFFICE VISIT NEW PATIENT COMPREHENSIVE	325.00	
05/25/2012		97010 HOT/COLD PACK PT	50.00	
05/25/2012		97012 MECHANICAL TRACTION	65.00	
05/25/2012		72052 X-RAY EXAM SPINE, CERVICAL, COMPLETE	225.00	
05/25/2012		72070 X-RAY EXAM SPINE, THORACIC, 2 VIEWS	150.00	
05/25/2012		72114 XRAY, COMPLETE L/S SPINE, BENDING VIEWS	250.00	
02/14/2013		INSURANCE PAYMENT	-975.17	
02/14/2013		PARTICIPATING ADJUSTMENT	-39.83	
05/29/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
05/29/2012		97010 HOT/COLD PACK PT	50.00	
05/29/2012		97012 MECHANICAL TRACTION	65.00	
02/14/2013		INSURANCE PAYMENT	-133.04	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.96	
05/30/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
05/30/2012		97010 HOT/COLD PACK PT	50.00	
05/30/2012		97012 MECHANICAL TRACTION	65.00	
02/14/2013		INSURANCE PAYMENT	-133.04	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.96	

BALANCE 2125.00 | 0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT.

BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
21-1910
CARRIE

MAKE CHECKS PAYABLE TO: ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727

MAKE CHECKS PAYABLE TO:

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
248-889-4580

IF PAYING BY CREDIT CARD,FILL OUT BELOW,CHECK CARD USED.

☐ MASTERCARD ☐ VISA

CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/05/2014	1910 21	

CARRIE MCDONALD
[redacted]

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
248-889-4580

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PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
06/04/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/04/2012		97010 HOT/COLD PACK PT	50.00	
06/04/2012		97012 MECHANICAL TRACTION	65.00	
02/14/2013		INSURANCE PAYMENT	-133.04	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.96	
06/06/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/06/2012		97010 HOT/COLD PACK PT	50.00	
06/06/2012		97012 MECHANICAL TRACTION	65.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
06/08/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/08/2012		97010 HOT/COLD PACK PT	50.00	
06/08/2012		97012 MECHANICAL TRACTION	65.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
06/13/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/13/2012		97010 HOT/COLD PACK PT	50.00	
06/13/2012		97012 MECHANICAL TRACTION	65.00	
		BALANCE	2125.00	0.00

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BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
21-1910
CARRIE

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0.00	02/05/2014	1910 21	

[redacted]

CARRIE MCDONALD
[redacted]

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
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DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
06/18/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/18/2012		97012 MECHANICAL TRACTION	65.00	
06/18/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
06/20/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/20/2012		97012 MECHANICAL TRACTION	65.00	
06/20/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
06/25/2012		99213 OFFICE VISIT ESTABLISHED PT MODERATE	150.00	
06/25/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/25/2012		97140 MANUAL TRACTION, TRIGGER PT RELEASE	70.00	
06/25/2012		97012 MECHANICAL TRACTION	65.00	
06/25/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-224.41	

BALANCE 2125.00 | 0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT.

BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
21-1910
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IF PAYING BY CREDIT CARD,FILL OUT BELOW,CHECK CARD USED.

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AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/05/2014	1910 21	

CARRIE MCDONALD
[redacted]

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
248-889-4580

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DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
02/14/2013		PARTICIPATING ADJUSTMENT	-60.59	
06/27/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/27/2012		97012 MECHANICAL TRACTION	65.00	
06/27/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
07/06/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
07/06/2012		97012 MECHANICAL TRACTION	65.00	
07/06/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
07/09/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
07/09/2012		97012 MECHANICAL TRACTION	65.00	
07/09/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
07/13/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
07/13/2012		97012 MECHANICAL TRACTION	65.00	

BALANCE 2125.00 0.00

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BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

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[redacted]

CARRIE MCDONALD

[redacted]

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STERLING HEIGHT MI 48312-1727
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DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
07/13/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
07/18/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
07/18/2012		97012 MECHANICAL TRACTION	65.00	
07/18/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
07/25/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
07/25/2012		97012 MECHANICAL TRACTION	65.00	
07/25/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
07/30/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
07/30/2012		97012 MECHANICAL TRACTION	65.00	
07/30/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	

BALANCE 2125.00 | 0.00

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BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
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0.00	02/05/2014	1910 21	

[redacted]

CARRIE MCDONALD
[redacted]

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
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DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
08/03/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
08/03/2012		97012 MECHANICAL TRACTION	65.00	
08/03/2012		97010 HOT/COLD PACK PT	50.00	
07/29/2013		INSURANCE PAYMENT	-133.63	
07/29/2013		PARTICIPATING ADJUSTMENT	-11.37	
08/10/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
08/10/2012		97012 MECHANICAL TRACTION	65.00	
08/10/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-133.63	
02/14/2013		PARTICIPATING ADJUSTMENT	-11.37	
08/21/2012		99213 OFFICE VISIT ESTABLISHED PT MODERATE	150.00	
08/21/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
08/21/2012		97012 MECHANICAL TRACTION	65.00	
08/21/2012		97010 HOT/COLD PACK PT	50.00	
02/14/2013		INSURANCE PAYMENT	-234.05	
02/14/2013		PARTICIPATING ADJUSTMENT	-60.95	
09/10/2012		99213 OFFICE VISIT ESTABLISHED PT MODERATE	150.00	
09/10/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	

BALANCE 2125.00 | 0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT.

BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
21-1910
CARRIE

MAKE CHECKS PAYABLE TO: ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727

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13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
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☐ MASTERCARD ☐ VISA

CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/05/2014	1910 21	

CARRIE MCDONALD
[redacted]

ELITE CHIROPRACTIC PC
13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727
248-889-4580

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PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	– CONTINUE –		
09/10/2012		97012 MECHANICAL TRACTION	65.00	
09/10/2012		97010 HOT/COLD PACK PT	50.00	
07/29/2013		INSURANCE PAYMENT	-234.11	
07/29/2013		PARTICIPATING ADJUSTMENT	-60.89	
09/19/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
09/19/2012		97012 MECHANICAL TRACTION	65.00	
09/19/2012		97010 HOT/COLD PACK PT	50.00	
07/29/2013		INSURANCE PAYMENT	-133.90	
07/29/2013		PARTICIPATING ADJUSTMENT	-11.10	
10/15/2012		99213 OFFICE VISIT ESTABLISHED PT MODERATE	150.00	
10/15/2012		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
10/15/2012		97012 MECHANICAL TRACTION	65.00	
10/15/2012		97112 NEUROMUSCULAR REEDUCATION	55.00	
10/15/2012		97110 THERAPEUTIC EXERCISE, EACH 15 MINUTES	55.00	
10/15/2012		97010 HOT/COLD PACK PT	50.00	
07/29/2013		INSURANCE PAYMENT	-343.77	
07/29/2013		PARTICIPATING ADJUSTMENT	-61.23	
01/11/2013		99213 OFFICE VISIT ESTABLISHED PT MODERATE	150.00	

BALANCE 2125.00 | 0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT.

BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

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0.00	02/05/2014	1910 21	

CARRIE MCDONALD
[redacted]

ELITE CHIROPRACTIC PC
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DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
01/11/2013		98940 MANIPULATION TREATMENT 1-2 REGIONS	35.00	
01/11/2013		97010 HOT/COLD PACK PT	50.00	
01/11/2013		97012 MECHANICAL TRACTION	65.00	
02/11/2013		99212 OFFICE VISIT ESTABLISHED PT LIMITED	100.00	
02/11/2013		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
02/11/2013		97010 HOT/COLD PACK PT	50.00	
02/11/2013		97012 MECHANICAL TRACTION	65.00	
04/18/2013		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
04/18/2013		97140 MANUAL TRACTION, TRIGGER PT RELEASE	70.00	
06/27/2013		98941 MANIPULATION TREATMENT 3-4 REGIONS	80.00	
06/27/2013		97140 MANUAL TRACTION, TRIGGER PT RELEASE	70.00	

BALANCE 2125.00 | 0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT.

BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
21-1910
CARRIE

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13927 PLUMBROOK ROAD
STERLING HEIGHT MI 48312-1727

AMERICAN ANESTHESIA ASSOCIATES, LLC
5623 E. DUNBAR ROAD
MONRIOE,MI 48161-9127
734-241-3891

TO: ROULA /MICHAEL MORSE, ATTORNEY
FAX: 855-776-8518

FROM: AMERICAN ANESTHESIA ASSOCIATES,LLC

REFERENCE: (PATIENT) CARRIE MCDONALD
DOB: [redacted]1968

BALANCE: $ 1,078.00

Please see enclosed outstanding bill for the above patient.

Please include this bill during settlement.

Thank you.

American Anesthesia Associates,LLC
(734) 241-3891

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

MICHAEL MORSE **
LAWYER
24901 N WESTERN HYW
STE 700
SOUTHFIELD MI 48075

CARRIER

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) X		1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]2697
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1968 SEX M / F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self X / Spouse / Child / Other	7. INSURED'S ADDRESS (No., Street): [redacted]
CITY: [redacted] STATE: MI	8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student	CITY: [redacted] STATE: MI
ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]		ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]2697	a. EMPLOYMENT? (Current or Previous) YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1968 SEX M / F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: [redacted]1968 M / F	b. AUTO ACCIDENT? YES / X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: MICHAEL MORSE **
d. INSURANCE PLAN NAME OR PROGRAM NAME: CITY OF DETROIT W/C **	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 03 13 13

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 03 12 13	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: RADDEN, LOUIS	17a. / 17b. NPI 1184675886	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 72210 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ANES TIME 08.40-08.56										
03 13 13 03 13 13	11		01992	QZ	1	539 00	01		NPI	1063466928
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									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
[redacted]6928 X	[redacted]1270 S	X YES / NO	$ 539 00	$ 00	$ 539 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
CRNA, DAVID WHITESELL	SPINE SPECIALISTS OF MICH 28426 W 8 MI RD, UNIT A4 FARMINGTON HILLS MI 48336-5	(734) 241-3891 AMERICAN ANESTHESIA ASSOC LLC 5623 E. DUNBAR ROAD MONROE MI 48161-9127
SIGNED 10161 DATE	a. 1891822565 b.	a. 1083959548 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SIGNED FIELD

NUCC Instruction Manual available at: www.nucc.org

MORSE

WCMS-1500CS

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

MICHAEL MORSE **
LAWYER
24901 N WESTERN HYW
STE 700
SOUTHFIELD MI 48075

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]2697

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE

3. PATIENT'S BIRTH DATE MM DD YY: 01 31 1968 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: MI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: [redacted] STATE: MI

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]2697

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1968 | SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: [redacted]1968 | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MICHAEL MORSE **

d. INSURANCE PLAN NAME OR PROGRAM NAME: CITY OF DETROIT W/C **

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 02 13 13

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 02 12 13

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: RADDEN, LOUIS

17a.

17b. NPI: 1184675886

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 72210

2.

3.

4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ANES TIME 11.25-11.47											
02 13 13	02 13 13	11		01992	QZ	1	539 00	01		NPI	1063466928
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted]6928 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: S [redacted]1270

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 539 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 539 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

DAVID WHITESELL, CRNA

SIGNED 101613 DATE

32. SERVICE FACILITY LOCATION INFORMATION

SPINE SPECIALISTS OF MICH
28426 W 8 MI RD, UNIT A4
FARMINGTON HILLS MI 48336-5

a. [redacted]1891822565 b.

33. BILLING PROVIDER INFO & PH. #: (734) 241-3891

AMERICAN ANESTHESIA ASSOC LLC
5623 E. DUNBAR ROAD
MONROE MI 48161-9127

a. [redacted]1083959548 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND COPY

CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0008 FORM CMS-1500 (08/05)

MORSE

WCMS-1500GS

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

May 7, 2013

Helen Manesia
25657 Southfield Road
Southfield, MI 48075

D/I: May 23, 2012
Re: CARRIE MCDONALD
Medicaid ID#: [redacted]7094
Amount: $126.94

Dear Ms. Manesia:

We have been informed that you have been retained for the purpose of seeking recovery for personal injury arising out of the incident referenced above. Please be advised that the Michigan Department of Community Health (MDCH) has a subrogation interest regarding Medicaid payments relative to the above-referenced incident. If the beneficiary has been enrolled in a Medicaid Managed Care Plan, the plan is identified below and should be contacted directly regarding its interest. Please note that Medicaid and Medicaid Managed Care Plans are separate entities; **their subrogation interests must be resolved separately.**

Section 106 of the Social Welfare Act, MCL 400.106, provides that MDCH is subrogated to any right of recovery that the beneficiary may have for the cost of medical care. In their application for assistance, the beneficiary executed an assignment of benefits to MDCH for recoveries related to medical expenditures made by the Medicaid program. Additionally, the beneficiary must advise MDCH of the commencement of any action or proceeding for the recovery of medical expenditures. MDCH is authorized to intervene or join in any proceeding to recover such expenditures. Further, except for Medicare, MDCH has first priority against any proceeds for the net recovery from any settlement. See MCL 400.106 (3)-(5).

We look forward to working cooperatively with your office to determine the appropriate action to take in this matter. We would appreciate receiving any information you have regarding any third parties who may be liable for our medical expenditures, especially any administrative or court actions that you intend to commence, and copies of any associated pleadings.

Upon receipt of your client's executed assignment and medical authorization (copies enclosed), we will furnish you with an itemized listing of Medicaid payments. Please contact our office for an updated lien amount prior to resolution of this case.

Thank you for your cooperation. If you have any questions, please contact our office.

Sincerely,

Jilaina Walker

Jilaina Walker
Third Party Liability Division
Telephone: (517) 335-8760

Health Plans:
Molina Healthcare of MI
100 W. Big Beaver Rd.
Suite 600
Troy, MI 48084

Michigan Department of Community Health **PRINT DATE:** 05/07/2013

Medicaid Report of Medical Services Paid

RECIPIENT ID [redacted]7094 **BIRTH DATE** [redacted]/1968 **ACCIDENT DATE/NO** 05/23/20 / 1

RECIPIENT NAME CARRIE MCDONALD

1467755876 **DMC PHARMACY DETROIT RECEIVING HOSPITAL**

Pharmacy (N/A)

TCN: **P61214410157711000**

001	05/23/2012		IBUPROFEN 600 MG TABLET	**Paid:** **$ 3.13**
55111068305				

Provider Total Amount Paid **$ 3.13**

1619289998 **DETROIT RECEIVING HOSPITA**

Outpatient OPPS

TCN: **31122301021695600O**

001	05/23/2012	9248	MULTIPLE CONTUSIONS NEC	**Paid:** **$ 75.24**
		7242	LUMBAGO	
		3051	TOBACCO USE DISORDER	
99283		HC	*EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND*	

Provider Total Amount Paid **$ 75.24**

1801843339 **LAFAYETTE DRUGS**

Pharmacy (N/A)

TCN: **P61215810166141000**

001	06/06/2012	CYCLOBENZAPRINE 10 MG TABLET	**Paid:** **$ 2.93**
00591565810			

TCN: **P61223410122083000**

001	08/21/2012	TOPIRAMATE 25 MG TABLET	**Paid:** **$ 3.70**
31722027860			

Provider Total Amount Paid **$ 6.63**

Michigan Department of Community Health
Medicaid Report of Medical Services Paid

PRINT DATE: 05/07/2013

RECIPIENT ID	[redacted]7094	**BIRTH DATE**	**ACCIDENT DATE/NO**
RECIPIENT NAME	CARRIE MCDONALD	[redacted]/1968	05/23/20 / 1

1902855711 **MEDICAL CENTER EMERGENCY SVCS**

Professional

TCN: 311229310089824000

001	05/23/2012	71941	JOINT PAIN-SHLDER	**Paid: $ 41.94**
		7242	LUMBAGO	
		9248	SPRAIN NOS	
99283		HC	*EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND*	

Provider Total Amount Paid	**$ 41.94**

Total Amount Billed	**$ 1,418.17**
Total Medicaid Amount this Report	**$ 126.94**
Previous Medicaid Amount Reported	**$ 0.00**
Total Medicaid Amount Reported	**$ 126.94**
Amount Recovered to Date	**$ 0.00**
Net Amount Owed	**$ 126.94**

Strictly Healing Transportation, Inc.
"Providing an Atmosphere for Total Healing"

23332 Farmington Rd. #716
Farmington, MI 48332
Office: (248) 476-4317
Fax: (248) 477-5999

Chauffeur Academy, Inc.
Compassionate Care Transportation, LLC
Executive Ground Transportation, Inc.
Love Joy Transportation, LLC

INVOICE

CPT Code: 98071
Date 9/14/2013
Invoice # 01040413MC
Customer ID MC0150
Claim Number:
Client's Name Carrie, McDonald

Tax ID#: [redacted]9398

Bill To:
Mike Morse Office
C/O Helen Manacia

Phone: (248) 350-9050
Fax: (866) 410-7855

Attorney: Helen Manacia

Run Type Rehab/Doctors Appointment
No. of Passengers: 1
Pick-up Time: 3:00 PM
Drop-Off Time: 4:30 PM
Driver

Payment / Charges: ☐ Billed/Account

☐ Visa ☐ MC ☐ Discover ☐ Amex
Card#_____ Exp Date_____
Cash Check# _____ Amount

Description	Charges	Hrs/Miles	Trips/Units	Amount
Base Trip Rate	$45.00		4	$180.00
Load Rate	$5.00		4	$20.00
Cost per Mile (*12 Miles & Over/Otherwise under=Base Rate*)	$3.75		0	
Total Miles	0			
Wait Time ($6.25 Per 1/4 Hour)	$25.00	1		$25.00
Over Mileage	$0.00	0		0.00
Total Due				$225.00
				-
				-

Special Services/Remarks

Wait with Client & Return / Round Trip Service
1st Stop: 7700 2nd Ave. Detroit, MI 48202 (Elite Health Center)
2nd Stop:
3rd Stop:
Dates of Service: April 4, & 18, 2013

Subtotal		$225.00
Taxable	$	-
Tax Rate		0.000%
Tax	$	-
Other	$	-
TOTAL Due		$225.00

Pick-Up At: Residence
Drop Off At: Residence

Make all checks payable to: *Strictly Healing Transportation, Inc.*

Thank You For Your Business!

Strictly Healing Transportation, Inc.

DRIVER DAILY TRIP LOG

Name of Account
JAZZ TYLER
Driver's Name (as it appears on drivers license)

Last Day Billed

Vehicle Number (Last six of the Vin #)

Date of Service	Claim/Job Number	Client's Name	Pick-Up Time	Drop Off Time	Total Wait Time Hours	Total Wait Time Cost	Load Rate	Per Trip Rate	Total Trip Mileage	Total Trip Billed Amount	Client's Signature
4/4		McDONALD, CARRIE	3:00 P	3:30 P	1/2	$12.50	$5.00	$45.00	5.3	$62.50	X Carrie McDonald
4/4		McDonald, CARRIE	4:00 P	4:30 P	/	/	$5.00	$45.00	5.3	$50.00	X Carrie McDonald
											TOTAL $112.50

****Note**** *Leg of Transport—a leg of transport is the point of pick-up to the destination. Example: Picking recipient up at residence and transporting to the doctor's office would be considered A leg; picking the recipient up at the doctor's office and transporting back to the residence would be considered the second leg of the trip. Each leg of the transport must be documented on separate lines. A signature is required for each leg of the transport.*

Driver's Comments: _____

I understand that Strictly Healing Transportation, Inc. will verify the accuracy of the mileage being reported and I hereby certify The information herein is true, correct, and accurate.

DRIVER'S SIGNATURE: Jazz Tyler

Strictly Healing Transportation, Inc.

DRIVER DAILY TRIP LOG

Name of Account: TAZZ TYLER

Driver's Name (as it appears on drivers license)

Last Day Billed

Vehicle Number (Last six of the Vin #)

Date of Service	Claim/Job Number	Client's Name	Pick-Up Time	Drop Off Time	Total Wait Time Hours	Total Wait Time Cost	Load Rate	Per Trip Rate	Total Trip Mileage	Total Trip Billed Amount	Client's Signature
4/18		McDONALD, CARRIE	1:45p	2:00p	1/2	$12.50	$5.00	$45.00	5.3	$62.50	XCarrie McDonald
4/18		McDONALD, CARRIE	2:30	2:50	/	/	$5.00	$45.00	5.3	$50.00	XCarrie McDonald
											TOTAL $112.50

Note *Leg of Transport—a leg of transport is the point of pick-up to the destination. Example: Picking recipient up at residence and transporting to the doctor's office would be considered A leg; picking the recipient up at the doctor's office and transporting back to the residence would be considered the second leg of the trip. Each leg of the transport must be documented on separate lines. A signature is required for each leg of the transport.*

Driver's Comments: _____

I understand that Strictly Healing Transportation, Inc. will verify the accuracy of the mileage being reported and I hereby certify The information herein is true, correct, and accurate.

DRIVER'S SIGNATURE: Tazz Tyler

Spine Specialists of Michigan, PC

32270 Telegraph Rd, Ste 110 * Bingham Farms, MI 48025 * (248)792-9496 (office) *(248)792-9628 (fax)
Louis N. Radden, DO —Board Certified -- Reconstructive Spine Surgeon

877-
378-
3896

FAX

TO: BRETT

FROM:

SUBJECT: DR. RADDEN

DATE:

1. CARRIE McDONALD
$16,105.-

[redacted]

fax252013

CITY OF DETROIT/ LAW DEPARTME
660 WOODWARD AVENUE, STE.1806

DETROIT MI 48226

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]2697

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE J

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1968 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: [redacted] STATE: MI

8. PATIENT STATUS: Single Married Other X; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1968 SEX M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES X NO PLACE (State) MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LOUIS N RADDEN DO

17a.

17b. NPI 1184675886

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 722.0
2. 722.10
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 08 20 12	10 08 20 12	11		99205		12	500.00	1		NPI	1184675886
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0797 EIN X

26. PATIENT'S ACCOUNT NO.: 341490

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 500.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 500.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOUIS N RADDEN DO

SIGNED 01/30/2014 DATE

32. SERVICE FACILITY LOCATION INFORMATION

SPINE SPECIALISTS OF MICHI
32270 TELEGRAPH RD SUITE11
BINGHAM FARMS MI 48025

a. 1184675886 b.

33. BILLING PROVIDER INFO & PH # (2489218096

SPINE SPECIALISTS OF MICHIGAN
28426 WEST 8 MILE SUITE A4
FARMINGTON HILLS MI 48336-594

a. 1891822565 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CITY OF DETROIT/ LAW DEPARTME
660 WOODWARD AVENUE, STE.1800

DETROIT MI 48226

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)			1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]2697
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MCDONALD CARRIE J	3. PATIENT'S BIRTH DATE MM DD YY 01 31 1968 SEX M ☐ F ☒		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street) SAME
CITY [redacted] STATE MI	8. PATIENT STATUS Single ☐ Married ☐ Other ☒		CITY STATE
ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]	Employed ☐ Full-Time Student ☐ Part-Time Student ☐		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒		a. INSURED'S DATE OF BIRTH MM DD YY [redacted]1968 SEX M ☐ F ☒
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State) MI		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☒		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE LOUIS N RADDEN DO	17a. 17b. NPI 1184675886	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 722.0 2. 722.10 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 17 2012 12 17 2012	11		99214		12	350.00	1		NPI	1184675886
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0797	26. PATIENT'S ACCOUNT NO. 401690	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐	28. TOTAL CHARGE $ 350.00	29. AMOUNT PAID $ 0.00	30. BALANCE DUE 350.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) LOUIS N RADDEN DO SIGNED 12/30/2014	32. SERVICE FACILITY LOCATION INFORMATION SPINE SPECIALISTS OF MICHI 32270 TELEGRAPH RD SUITE11 BINGHAM FARMS MI 48025 a. 1184675886 b.	33. BILLING PROVIDER INFO & PH # (2489218096 SPINE SPECIALISTS OF MICHIGAN 28426 WEST 8 MILE SUITE A4 FARMINGTON HILLS MI 48336-594 a. 1801822560 b.

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CITY OF DETROIT/ LAW DEPARTME
660 WOODWARD AVENUE, STE.1800

DETROIT MI 48226

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

CARRIER

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]2697

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE J

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1968 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: [redacted] STATE: MI

8. PATIENT STATUS: Single Married Other X

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1968 SEX: M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. AUTO ACCIDENT? YES X NO PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LOUIS N RADDEN DO

17a.

17b. NPI 1184675886

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L 722.0 3. L 840.4

2. L 722.10 4. L

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07162013 07162013	11		99214		123	350.00	1		NPI	1184675886
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0797 X

26. PATIENT'S ACCOUNT NO.: 578950

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 350.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 350.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOUIS N RADDEN DO

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

SPINE SPECIALISTS OF MICHI
32270 TELEGRAPH RD SUITE11
BINGHAM FARMS MI 48025

a. [redacted] b.

33. BILLING PROVIDER INFO & PH # (2489218096)

SPINE SPECIALISTS OF MICHIGAN
28426 WEST 8 MILE SUITE A4
FARMINGTON HILLS MI 48336-594

a. [redacted] b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CITY OF DETROIT/ LAW DEPARTME
660 WOODWARD AVENUE, STE.1800

DETROIT MI 48226

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]2697

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE J

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1968 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: [redacted] STATE: MT

8. PATIENT STATUS: Single Married Other X; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1968 SEX: M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. AUTO ACCIDENT? YES X NO PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LOUIS N RADDEN DO

17a.

17b. NPI 1184675886

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 722.10 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03132013	03132013	11		62311		1	2000.00	1		NPI	1184675886
2 03132013	03132013	11		64493	RT	1	2250.00	1		NPI	1184675886
3 03132013	03132013	11		64493	LT	1	2250.00	1		NPI	1184675886
4 03132013	03132013	11		64494	RT	1	2250.00	1		NPI	1184675886
5 03132013	03132013	11		64494	LT	1	2250.00	1		NPI	1184675886
6 03132013	03132013	11		77003		1	300.00	1		NPI	1184675886

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0797 X

26. PATIENT'S ACCOUNT NO.: 619130

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 11300.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: 11300.00

31. [redacted] OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOUIS N RADDEN DO

SIGNED [redacted]

32. SERVICE FACILITY LOCATION INFORMATION

SPINE SPECIALISTS OF MICHI
32270 TELEGRAPH RD SUITE11
BINGHAM FARMS MI 48025

a. [redacted] b. [redacted]

33. BILLING PROVIDER INFO & PH # (2489218096

SPINE SPECIALISTS OF MICHIGAN
28426 WEST 8 MILE SUITE A4
FARMINGTON HILLS MI 48336-594

a. [redacted] b. [redacted]

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

CITY OF DETROIT/ LAW DEPARTME
660 WOODWARD AVENUE, STE.1800

DETROIT MI 48226

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): A32950002697

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE J

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1968 | SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: [redacted] | STATE: MI

8. PATIENT STATUS: Single | Married | Other X

ZIP CODE: [redacted] | TELEPHONE (Include Area Code): [redacted]

Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES | NO X

8. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 1968 | SEX: M | F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? YES X | NO | PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LOUIS N RADDEN DO

17a.

17b. NPI 1184675886

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L722.10 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03132013 03132013	11		72275		1	1400.00	1		NPI	1184675886
2	03132013 03132013	11		J1040		1	880.00	2		NPI	1184675886
3	03132013 03132013	11		A4550		1	375.00	1		NPI	1184675886
4	03132013 03132013	11		A9579		1	600.00	1		NPI	1184675886
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted]0797 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 619130

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X | NO

28. TOTAL CHARGE: $ 3255.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 3255.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOUIS N RADDEN DO

SIGNED 13 DATE 11/14/2013

32. SERVICE FACILITY LOCATION INFORMATION

SPINE SPECIALISTS OF MICH
32270 TELEGRAPH RD SUITE11
BINGHAM FARMS MI 48025

a. 1891822565 b.

33. BILLING PROVIDER INFO & PH # (2489218096

SPINE SPECIALISTS OF MICHIGAN
28426 WEST 8 MILE SUITE A4
FARMINGTON HILLS MI 48336-594

a. 1891822565 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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CITY OF DETROIT/ LAW DEPARTME
660 WOODWARD AVENUE, STE.1800

DETROIT MI 48226

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]2697

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MCDONALD CARRIE J

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1968 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: [redacted] STATE: MI

6. PATIENT STATUS: Single Married Other X

CITY STATE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1968 SEX: M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. AUTO ACCIDENT? YES X NO PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LOUIS N RADDEN DO

17a.

17b. NPI 1184675886

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 722.10
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10302013	10302013	22		99214		1	350.00	1		NPI	1184675886
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
[redacted]0797	[redacted]	YES X NO	$ 350.00	$ 0.00	350.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOUIS N RADDEN DO

SIGNED 01/30/2014 DATE

32. SERVICE FACILITY LOCATION INFORMATION

BEAUMONT HOSPITAL
3601 W 13 MILE ROAD
ROAYL OAK MI 48073

33. BILLING PROVIDER INFO & PH # (2489218096

SPINE SPECIALISTS OF MICHIGAN
28426 WEST 8 MILE SUITE A4
FARMINGTON HILLS MI 48336-594

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Detroit Magnolia Luxury Tours& Charters
9494 French Rd.
Detroit,Mi 48213
(313)915-8576 or (313)447-7298
Fax: (313)571-9479

Date: November 14, 2012

Insurance Agent:
Adjuster Name:
Insurance Address:

Client: Carrie McDonald
Claim Number: [redacted]2697

Explanation of Charges

$45.00 pickup
$45.00 dropoff
$90.00 a day
=$2,520.00

534 miles at a rate of $4.00 per mile
=$2,136.00

Date of Services: 9/24/2012- 11/7/2012
28Trips

Total: $ 4,656.00

Company Name: Detroit Magnolia Luxury Tours LLC

Name of Recipient: Claim# A32950-002497 Driver Name: ______ Driver Number: ______

ASC Trip #	Recipient's Name	Service Type	Pickup Time	PU Address	Will Call Time	Drop-off Time	Destination Address	Recipient Signature
9/24/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield, MI	Carrie McDonald
10/3/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald
10/5/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald
10/8/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald
10/10/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald
10/15/2012	Carrie McDonald						7100 [illegible] Detroit MI	Carrie McDonald
10/17/2012	Carrie McDonald						30770 Southfield [illegible]	Carrie McDonald
10/19/2012	Carrie McDonald						30770 Southfield Detroit MI	Carrie McDonald
10/19/2012	Carrie McDonald						30770 Southfield [illegible]	Carrie McDonald
10/22/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald
10/24/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald
10/26/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald
10/31/2012	Carrie McDonald						30770 Southfield Rd Southfield, MI	Carrie McDonald
11/2/2012	Carrie McDonald						30770 Southfield Southfield, MI	Carrie McDonald

Signature: [signature]

Driver Log.xls - GCM2008

Company Name: Detroit Magnolia Luxury Tours LLC

Date of Service: _____ Driver Name: _____ Driver Number: _____

ADC Trip #	Passenger's Name	Service Type	Pickup Time	Pick Up Address	Will Call Time	Drop off Time	Destination Address	Passenger Signature
11/5/2012	Carrie McDonald			[redacted]			3070 South Telegraph Southfield, MI	Carrie McDonald
11/6/2012	Carrie McDonald						7700 Second St Detroit, MI	Carrie McDonald
11/7/2012	Carrie McDonald						3070 South Telegraph Southfield, MI	Carrie McDonald
11/8/2012	Carrie McDonald						3070 South Telegraph Southfield, MI	Carrie McDonald
11/9/2012	Carrie McDonald						3070 South Telegraph Southfield, MI	Carrie McDonald
11/10/2012	Carrie McDonald						3070 South Telegraph Southfield, MI	Carrie McDonald
11/11/2012	Carrie McDonald						3070 South Telegraph Southfield, MI	Carrie McDonald
								Carrie McDonald
								Carrie McDonald
								Carrie McDonald
								Carrie McDonald
								Carrie McDonald
								Carrie McDonald
								Carrie McDonald

Signature: Barbara Lore

Detroit Magnolia Luxury Tours& Charters
9494 French Rd.
Detroit,Mi 48213
(313)915-8576 or (313)447-7298
Fax: (313)571-9479

Date February 14, 2013

Insurance Agent:
Adjuster Name:
Insurance Address:

Client: Carrie McDonald
Claim Number:[redacted]2697

Explanation of Charges

$45.00 pickup
$45.00 dropoff
$90.00 a day
=$1,620.00

332 miles at a rate of $4.00 per mile
=$1,328.00

Date of Services: 11/5/2012- 12/17/2012
28Trips

Total: $ 3,056.00

Claim# Date of Service: [redacted] 2697 Company Name: Detroit Magnolia Luxury Towncar LLC
Driver Name: ______ Driver Number: ______

A2C Trip #	Recipient's Name	Service Type	Pickup Time	PU Address	Will Call Time	Drop off Time	Destination Address	Recipient Signature
11/5/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald
11/7/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald
11/8/2012	Carrie McDonald			[redacted]			7700 Second St Detroit MI	Carrie McDonald
11/12/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald
11/14/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald
11/19/2012 11/[illegible]/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald
11/21/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald
12/3/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald
12/17/2012	Carrie McDonald			[redacted]			30770 Southfield Southfield MI	Carrie McDonald

Signature: B Love

Driver Log.ab - 02082008

TAXICAB RECEIPT

Detroit, Michigan roundtrip

AMOUNT 85.00 DATE 5-13-2013

FROM [redacted]

TO 32270 Telegraph

CAB# 448 DRIVER Mitchell Whitehead Thank you!

Medical Mileage Form

Client Name: Carrie McDonald

Dates of Service	Doc/Provider Address	Round Trip Miles
5-13-13		85.00 Sub
5-13-13		

Dated: 5-13-13

Signature: Mitchell Whitehead

[redacted]

Ambulatory Anesthesia Associates, PC
P O BOX 674492
DETROIT, MI 48267-4492

IF PAYING BY VISA, MASTERCARD OR DISCOVER, FILL OUT BELOW

☐ VISA ☐ MASTERCARD ☐ DISCOVER

CARD NUMBER | EXP. DATE | AMOUNT

CARD HOLDER SIGNATURE | (MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD)

PLEASE PRINT CARD HOLDER NAME HERE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
05/03/2013	Minimum Amount Due $360.00	[redacted]3067

For all billing questions, call: 586-838-5033
Office Hours: 8:00 A.M. - 4:00 P.M.
To pay online please visit: https://pay.instamed.com/AAA

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

MAKE CHECKS PAYABLE / REMIT TO:

20038 - 32

CARRIE J MCDONALD
[redacted]

Ambulatory Anesthesia Associates, PC
P O BOX 674492
DETROIT, MI 48267-4492

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

Date	Description	Procedure	Insurance Charges/ Credits	Patient Charges/ Credits
	MCDONALD, CARRIE			
01/16/2013	Professional CRNA Anesthesia Services	62311	360.00	
04/02/2013	Guarantor Responsibility			360.00

ACCOUNT STATUS	CURRENT	31-60 DAYS	61-90 DAYS	91-120 DAYS	OVER 120 DAYS	TOTAL BALANCE	INSURANCE BALANCE	PATIENT BALANCE
	$0.00	$360.00	$0.00	$0.00	$0.00	$360.00	$0.00	$360.00

To pay online please visit: https://pay.instamed.com/AAA

Please Pay This Amount →
Minimum Amount Due: $360.00

Your account is now PAST DUE. Payment is due immediately. Our records indicate the amount shown is your responsibility. If there is a reason for non-payment, please contact our office today.

Ambulatory Anesthesia Associates, PC
Account #: 630123067
For all billing questions: 586-838-5033
Office Hours: 8:00 A.M. - 4:00 P.M.
Pay Online at https://pay.instamed.com/AAA

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION
20038-32

MAKE CHECKS PAYABLE TO: [redacted]

MICHIGAN HEAD & SPINE INSTITUTE PC
2319 MOMENTUM PLACE
CHICAGO, IL 60689-5325

16466-690I

RETURN SERVICE REQUESTED

004542 0101

LAST PMT:
AMOUNT: 0.00

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

CARRIE MCDONALD
[redacted]

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
11/12/12	$5220.00	[redacted]6571

PAGE: 1 of 1

SHOW AMOUNT PAID HERE $

500120A

MICHIGAN HEAD & SPINE INSTITUTE PC
2319 MOMENTUM PLACE
CHICAGO, IL 60689-5325

16466-690I*TN50GP3O8000345

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

Date of Service	Patient	Date Ins Billed	Code	Dr	Description	Diag.	Charge	Insurance Receipts	Patient Receipts	Adjust.	Balance
08/14/12	CARRIE		70450	111	CT HEAD OR BRAIN W/OUT CONTRAST	7840	1660.00				1660.00
09/07/12	CARRIE		72131	111	CT SPINE LUMBAR W/OUT CONTRAST	7242	1800.00				1800.00
09/07/12	CARRIE		73700	111	CT LOWER EXTREMITY W/OUT CONTRAST	71945	1760.00				1760.00

Current	30-60 Days	60-90 Days	90-120 Days	120 Days +	Total Balance	* Ins. Pending	PATIENT DUE
0.00	0.00	5220.00	0.00	0.00	5220.00	0.00	$5220.00

Doctor Codes:
111 Robert Johnson, MD

Message
FOR PHYSICAL THERAPY BILLING CONCERNS CALL (248)351-6300

Make Checks Payable To:
MICHIGAN HEAD & SPINE INSTITUTE PC
2319 MOMENTUM PLACE
CHICAGO, IL 60689-5325

Billing Questions
(248)869-3981

000002998-A

16466-690I*TN50GP3O8000345

MAKE CHECKS PAYABLE TO:

R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242
248-889-4580

R & R TRANSPORTATION

IF PAYING BY CREDIT CARD,FILL OUT BELOW,CHECK CARD USED.

☐ MASTERCARD ☐ VISA

CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/11/2013	830 38	

CITY OF DETROIT LAW DEPARTMENT
660 WOODWARD AVE FIRST NATL BLD 1800
DETROIT, MI 48226

R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242
248-889-4580

01 R & R TRANSPORTATION

☐ Please check if address or insurance has changed. Make changes on reverse side.

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	ACCOUNT ACTIVITY PATIENT
		CARRIE MCDONALD		
	Date	Statement from 01/01/2012 to 02/11/2013		
07/25/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
08/03/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
08/10/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
08/14/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
08/21/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
09/07/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
09/10/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
09/10/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
09/13/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
09/19/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
09/20/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
09/24/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
10/02/2012	~NOTE	STATEMENT NOTE		
		CITY OF DETROIT CLAIM #364822691		
12/20/2012	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00
01/11/2013	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)		120.00

BALANCE

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT
BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
38-830
CITY OF DETROIT

MAKE CHECKS PAYABLE TO: R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242

MAKE CHECKS PAYABLE TO:

R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242
248-889-4580

R & R TRANSPORTATION

IF PAYING BY CREDIT CARD,FILL OUT BELOW,CHECK CARD USED.

☐ MASTERCARD ☐ VISA

CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/11/2013	830 38	

CITY OF DETROIT LAW DEPARTMENT
660 WOODWARD AVE FIRST NATL BLD 1800
DETROIT, MI 48226

R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242
248-889-4580

01 R & R TRANSPORTATION

☐ Please check if address or insurance has changed. Make changes on reverse side.

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	ACCOUNT ACTIVITY PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
01/21/2013	A0110	TRANSPORT (PICK UP, DROP OFF & MILES)	120.00	
02/07/2013	INSPA	INSURANCE PAYMENT	-15.00	
	3255411			
02/07/2013	PARAD	PARTICIPATING ADJUSTMENT	-105.00	
02/07/2013	INSPA	INSURANCE PAYMENT	-15.00	
	3255411			
02/07/2013	PARAD	PARTICIPATING ADJUSTMENT	-105.00	
02/07/2013	INSPA	INSURANCE PAYMENT	-23.62	
	3255411			
02/07/2013	PARAD	PARTICIPATING ADJUSTMENT	-216.38	
02/07/2013	INSPA	INSURANCE PAYMENT	-10.71	
	3255411			
02/07/2013	PARAD	PARTICIPATING ADJUSTMENT	-109.29	
02/07/2013	INSPA	INSURANCE PAYMENT	-32.13	
	3255411			
02/07/2013	PARAD	PARTICIPATING ADJUSTMENT	-327.87	
02/07/2013	INSPA	INSURANCE PAYMENT	-21.42	
	3255411			

BALANCE

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT
BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
38-830
CITY OF DETROIT

MAKE CHECKS PAYABLE TO: R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242

MAKE CHECKS PAYABLE TO:

R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242
248-889-4580

R & R TRANSPORTATION

IF PAYING BY CREDIT CARD, FILL OUT BELOW, CHECK CARD USED.

☐ MASTERCARD ☐ VISA

CARD NUMBER AMOUNT

SIGNATURE EXP.DATE

AMOUNT DUE NOW	STATEMENT DATE	ACCOUNT NUMBER	AMOUNT ENCLOSED
0.00	02/11/2013	830 38	

CITY OF DETROIT LAW DEPARTMENT
660 WOODWARD AVE FIRST NATL BLD 1800
DETROIT, MI 48226

R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242
248-889-4580

01 R & R TRANSPORTATION

☐ Please check if address or insurance has changed. Make changes on reverse side.

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS STATEMENT WITH YOUR PAYMENT. RETAIN THE BOTTOM PORTION FOR YOUR RECORDS.

DATE	PATIENT	DESCRIPTION	ACCOUNT ACTIVITY INSURANCE	PATIENT
	CARRIE MCDONALD	-- CONTINUE --		
02/07/2013	PARAD	PARTICIPATING ADJUSTMENT	-218.58	
02/07/2013	INSPA	INSURANCE PAYMENT	-21.42	
	3255411			
02/07/2013	PARAD	PARTICIPATING ADJUSTMENT	-218.58	

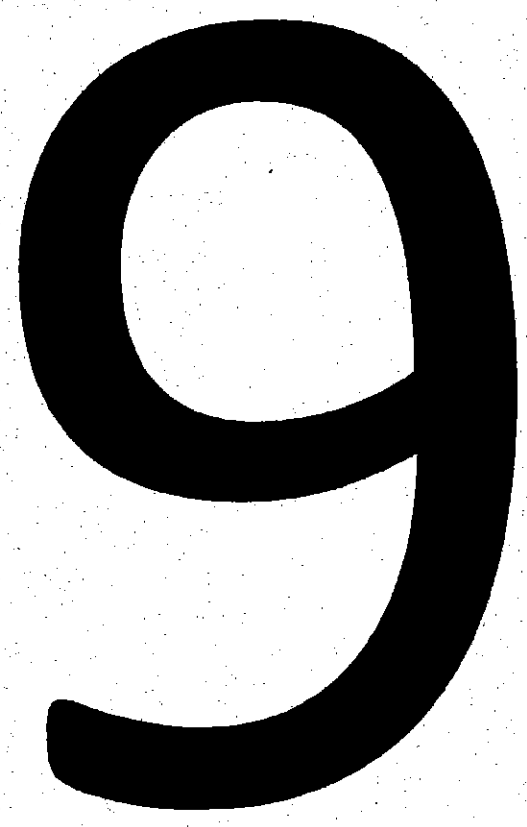
BALANCE	360.00	0.00

PLEASE MAKE PAYMENT IN FULL UPON RECEIPT
BILLING QUESTIONS PLEASE CALL 248-889-4580

0-30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	120+ DAYS
0.00	0.00	0.00	0.00	0.00

ACCT:
38-830
CITY OF DETROIT

MAKE CHECKS PAYABLE TO: R & R TRANSPORTATION
363 WEST BIG BEAVER RD STE
TROY MI 48084-5242



AFFIDAVIT

STATE OF MICHIGAN)
SS
COUNTY OF WAYNE)

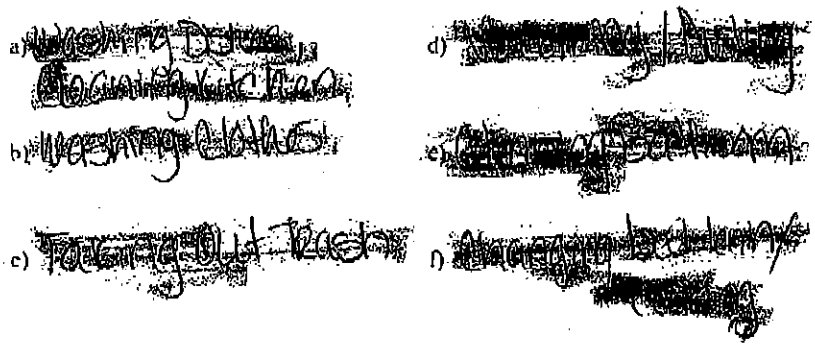
I, Danielle Matlock, being first duly sworn, depose and state as follows:

1. That I performed household chores for Carrie McDonald and [redacted] reside at [redacted]

My social security number is: [redacted]

2. That I have performed household chores for Carrie McDonald 7 days per week from 5/23/12 through 3/21/13 and 5 days per week from 4/1/13 through the present and ongoing.

3. By way of example, I was regular doing the following chores:



4. I am claiming $20.00 per day for each day of service that I have performed.

5. I have personal knowledge of the facts contained herein.

6. If sworn as a witness, I can competently testify to the facts contained herein.

FURTHER AFFIANT SAITH NOT.

Dated: [redacted]

[redacted]

Name

10

CFTG ENTERPRISES LLC				15350 FENKELL AVE				DETROIT MI 48227				Pay Date: 04/27/2012
EE # 54	CARRIE J MCDONALD			EEID 1[redacted]8-857		DEPT # 300		Direct Deposit Receipt: 1037218004				Period: 04/10/2012 to 04/24/2012
EARNING	RATE	HOUR/UNIT	CURRENT $	YTD HR/UNIT	YTD $	DEDUCTION	CURRENT $	YTD $	TAX	CURRENT $	YTD $	OTHER INFORMATION
Reg	10.00	23.60	236.00	461.80	4,618.00				FITWH MED SOC MI MIDETR	4.85 3.42 9.91 4.08 5.32	154.86 65.95 193.96 98.41 105.64	FITWH S 2 MI S 2
	TOTALS	23.60	236.00	461.80	4,618.00					27.58	617.83	NET 208.42

FOLD AND REMOVE Paycor

Do Not Accept This Check Without Verifying Security Features

CFTG ENTERPRISES LLC
15350 FENKELL AVE
DETROIT MI 48227

Direct Deposit Receipt # 1037218004
Date 04/27/2012

Pay this Amount

** NON-NEGOTIABLE ** DIRECT DEPOSIT RECEIPT **	VOID ** VOID **

VOID VOID VOID

Pay to the Order of CARRIE J MCDONALD 300 DD

[redacted]

DIRECT DEPOSIT $208.42
TO ACCOUNT # X4738
BANK # XXXXX9487

NON-NEGOTIABLE

CFTG ENTERPRISES LLC			15350 FENKELL AVE			DETROIT MI 48227						Pay Date: 03/02/2012
EE # 54	CARRIE J MCDONALD			EEID [redacted]8-857		DEPT # 300			Direct Deposit Receipt: 1035622343			Period: 02/22/2012 to 02/28/2012
EARNING	RATE	HOUR/UNIT	CURRENT $	YTD HR/UNIT	YTD $	DEDUCTION	CURRENT $	YTD $	TAX	CURRENT $	YTD $	OTHER INFORMATION
Reg	10.00	28.40	284.00	212.10	2,121.00				FITWH	9.65	53.10	
									MED	4.12	30.76	
									SOC	11.93	89.09	
									MI	6.16	37.30	
									MIDETR	6.52	47.83	
												FITWH S 2
												MI S 2
	TOTALS	28.40	284.00	212.10	2,121.00					38.38	258.08	NET 245.62

DO NOT ACCEPT THIS CHECK without confirming presence of Artificial Watermark on back. Other security features are listed on back.

VOID VOID VOID

CFTG ENTERPRISES LLC
15350 FENKELL AVE
DETROIT MI 48227

Direct Deposit Receipt # 1035622343
Date 03/02/2012

Pay this Amount

** NON-NEGOTIABLE ** DIRECT DEPOSIT RECEIPT **

** VOID ** VOID **

VOID VOID VOID

DIRECT DEPOSIT $245.62
TO ACCOUNT # X4736
BANK # XXXXX9487

Pay to the Order of CARRIE J MCDONALD [redacted]

300 DD

NON-NEGOTIABLE

VOID VOID VOID

EXHIBIT 6D – SETTLEMENT AGREEMENT

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re	:	Chapter 9
CITY OF DETROIT, MICHIGAN,	:	Case No. 13-53846
Debtor.	:	Hon. Steven W. Rhodes

AGREEMENT RESOLVING CLAIMS OF CARRIE MCDONALD

The City of Detroit (the "City") and the claimant identified in paragraph 2 below (the "Claimant" and, together with the City, the "Parties"), by and through their respective authorized representatives, do hereby agree as follows:

RECITALS:

On July 18, 2013, the City commenced the above-captioned case (the "Chapter 9 Case") by filing a petition for relief under chapter 9 of title 11 of the United States Code (the "Bankruptcy Code") in the United States Bankruptcy Court for the Eastern District of Michigan (the "Bankruptcy Court"). On December 5, 2013, following its determination that the City met all of the applicable requirements and is eligible to be a debtor under chapter 9 of the Bankruptcy Code, the Bankruptcy Court entered the Order for Relief Under Chapter 9 of the Bankruptcy Code (Docket No. 1946) with respect to the City.

A. Pursuant to section 904 of the Bankruptcy Code, the City may continue to exercise its political and governmental powers, manage its property and revenues and use and enjoy its income-producing property without interference from the Bankruptcy Court.

B. On December 24, 2013, the Bankruptcy Court entered the Order, Pursuant to Sections 105 and 502 of the Bankruptcy Code, Approving Alternative Dispute Resolution Procedures to Promote the Liquidation of Certain Pre-petition Claims (Docket No. 2302) (the "ADR Order") establishing certain alternative dispute resolution procedures (collectively, the "ADR Procedures") to promote the resolution of certain claims designated by the City.

C. The Claimant is the current record holder of the proof[s] of claim identified under the heading "Filed Claim Number" in the table in paragraph 2 below (the "Filed Claim").

D. The City (i) reviewed the Filed Claim and the facts and circumstances of the alleged liabilities asserted therein and (ii) designated the Filed Claim for potential resolution through the ADR Procedures.

E. The City believes that the resolution of the Filed Claim as set forth in this Agreement is fair, reasonable and appropriate and will allow the Parties to avoid the cost, delay and burden of litigating potential disputes related to the Filed Claim. In accordance with the ADR Order, the resolution of the Filed Claim set forth in this Agreement terminates the ADR Procedures with respect to the Filed Claim pursuant to section II.A.7 of the ADR Procedures.

F. Pursuant to section 904 of the Bankruptcy Code, the City is authorized to propose and enter into this Agreement without further order of the Bankruptcy Court.

H. The undersigned is authorized to enter into this Agreement on behalf of the City pursuant to a confidential memorandum dated March 25, 2014 that was issued to the City of Detroit Corporation Counsel by Kevyn Orr, Emergency Manager for the City of Detroit, entitled Litigation Claim Settlement Authority.

I. The Parties have agreed to the terms set forth in this Agreement, as indicated by the signatures of their respective authorized representatives below.

AGREEMENT

1. The Claimant represents and warrants to the City that it has not sold, assigned, factored or otherwise transferred any portion of or interest in the Filed Claim and is the sole holder of the Filed Claim, with full authority to enter into this Agreement. The Claimant further agrees to indemnify and hold the City harmless for any damages, including without limitation actual and reasonable out of pocket costs, resulting from a breach of its representations and warranties set forth in this paragraph.

2. The Filed Claim is deemed amended, modified and allowed as a general unsecured, nonpriority claim (any such claim, a "Settled Claim") in the corresponding amount set forth in the table below under the heading "Settled Claim Amount":

Claimant	Filed Claim Number	Filed Claim Amount	Filed Claim Priority	Settled Claim Amount	Settled Claim Priority
Carrie McDonald	**1542**	**$ 98,392.43**	**General unsecured**	**$50,000.00**	**General unsecured**

3. The Parties agree that any Filed Claim identified in paragraph 2 above for which there is no corresponding Settled Claim (or such amount is listed as $0.00) is hereby withdrawn and deemed disallowed and expunged, pursuant to section 502 of the Bankruptcy Code.

4. The Claimant will not further amend the Filed Claim (or the Settled Claim) or file any additional proofs of claim with respect to the liabilities asserted in the Filed Claim. Any further amendments to the Filed Claim (or the Settled Claim) or any additional claims filed by the Claimant or their successors or assigns with respect to the liabilities asserted in the Filed Claim shall be null, void and of no effect.

5. The Parties agree that any Settled Claim is a general unsecured, non-priority claim, subject to the treatment provided for such claims under any chapter 9 plan for the adjustment of debts confirmed by the Bankruptcy Court (a "Plan").

6. Any distribution made to the Claimant pursuant to a Plan is referred to herein as a "Plan Distribution." If the Claimant or its successors or assigns receive payment of any portion of the Settled Claims from any source, including from the City, other than through the Plan (a "Non-Plan Payment"), the portion of the Settled Claim equal to the amount of the Non-Plan Payments shall be deemed fully satisfied, and the Claimant, for itself and any successors or assigns, hereby prospectively waives and disclaims the right to receive Plan Distributions on account of the portion of the Settled Claim satisfied by any Non-Plan Payments.

7. Nothing in this Agreement will have any impact on any proof(s) of claim that the Claimant has filed or holds other than the Filed Claim. The Parties retain all of their respective claims, defenses, objections, counterclaims and any and all rights in respect of any proofs of claim that the Claimant has filed or holds other than the Filed Claim.

8. As to the Filed Claims and Settled Claims described herein, the Claimant releases the City from any and all liability, actions, damages and claims (including claims for attorney fees, expert fees or court costs), known and unknown, arising or accruing at any time prior to and after the date of this Agreement, that the Claimant has or may have against the City. The Claimant acknowledges that this Agreement represents the compromise of a disputed claim and is not to be construed as an admission of liability on the part of the City. As used in this Agreement, the Claimant and the City include each of their respective servants, agents, contractors, attorneys, employees, representatives, family members, heirs, elected officials, appointed officials, related corporations, subsidiaries, divisions, affiliates, directors and officers, if any. Where required by the City, the Claimant has executed the Medicare Reporting and Indemnification Affidavit[s], if any, attached as Exhibit A.

9. The Claimant stipulates to dismissal with prejudice of the civil action[s] related to the Filed Claims or Settled Claim in the form attached hereto as Exhibit B.

10. This Agreement may be executed in identical counterparts, and/or by facsimile or e-mail scan, each of which when so executed and delivered will constitute an original, but all of which taken together will constitute one and the same instrument. This Agreement constitutes the entire agreement between the Parties with respect to the matters addressed herein and may not be modified except in a writing signed by the Parties.

WHEREFORE, the undersigned have executed this Agreement on behalf of the parties hereto.

CITY OF DETROIT,

By: KRYSTAL A. CRITTENDON

Name: _____
(printed)

Title: Supervising Assistant Corporation Counsel

Date: _____

CARRIE MCDONALD

X Carrie McDonald
(signature)

Name: Carrie McDonald
(printed)

Date: _____

MICHAEL J. MORSE

Patricia Dooley
(signature)

Name: Patricia Dooley
(printed)

Date: 4/30/14.

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

CITY OF DETROIT, MICHIGAN,

Debtor.

Chapter 9

Case No. 13-53846
Claim #1542

Hon. Steven W. Rhodes

STIPULATION TO DISMISS CAUSE

The parties in the above-entitled cause by their respective attorneys, hereby stipulate and agree that an Order be entered forthwith dismissing the said claim with prejudice and without costs and attorney fees to any party.

MICHAEL J. MORSE (P46895)
LAW OFFICE OF MICHAEL J. MORSE
Attorneys for Plaintiff
24901 Northwestern Hwy #700
Southfield, MI 48075
248-350-9050

KIMBERLY A. JAMES (P56410)
CITY OF DETROIT LAW DEPT
Attorneys for Defendant
2 Woodward Avenue, 5th Floor
Detroit, MI 48226
313-237-5063

ORDER TO DISMISS CAUSE

At a session of the said Court held in the Courthouse, City of Detroit, County of Wayne, Michigan on

Present: Honorable _____
U.S. District Court Judge

Upon the reading and filing of the stipulation annexed hereto, and the Court being fully advised in the premises;

IT IS HEREBY ORDERED that the within cause be dismissed with prejudice and without costs and without attorney fees to any party; all pending claims are hereby resolved and this case is now closed.

U. S. DISTRICT COURT JUDGE

MEDICARE REPORTING AND INDEMNIFICATION AFFIDAVIT

Carrie McDonald being first duly sworn, deposes and says that I have filed a claim and/or lawsuit against the City of Detroit:

1. I certify under penalty of law that this Affidavit and all attachments were prepared with my knowledge and were reviewed by me. The information submitted is, to the best of my knowledge and belief, true, accurate and complete. I am aware that there are significant penalties for submitting false information, including the possibility of a fine and/or imprisonment for known violations. I hereby state under oath and subject to any penalties for perjury that the information contained in this Affidavit is true, correct and accurate.

2. I hereby understand that the City of Detroit will be relying upon this information in order to provide all of the required information to the United States Government, Department of Health and Human Services, Center for Medicare and Medicaid Services or their Medicare contractor in accordance with the Medicare, Medicaid and SCHIP Extension Act of 2007 and to be in compliance with the Medicare Secondary Payer Laws.

Circle One

3. I am currently receiving Medicare Benefits..... yes or (no)
4. I will be Sixty Five years old within three years..... yes or (no)
4a. I have applied for Social Security Disability Benefits..... yes or (no)
5. I have received a Social Security Disability Award Letter and attached a copy hereto.....yes or (no)
6. Attached is a copy of my Social Security Disability Application.....yes or (no)
7. Attached is a copy of my Social Security denial letter and my appeal of said denial..... yes or (no)

8. I have End Stage Renal Disease..... yes or no

9. That my full name and all aliases are:

Carne McDonald

10. That my City of Detroit File/Matter Number is:

1542

11. That my address is:

[redacted]

12. That my Attorney's Name, Address and Contact Numbers are:

Patty Dooley, Mike Morse, PC.
248-350-9050

13. That my Date of Birth is:

[redacted]68

14. That my Social Security Number is:

[redacted]2691

15. That my Medicare HIC Number, if applicable is:

N/A

16. That I am attaching copies of the following information:

a. Copy of the Judgment ..... yes or no

b. Medical Records ..... yes or no

17. Has anyone ever prepared for you:

a. A Life Care Plan..... yes or (no)

b. Medicare Set Aside Cost Projections .....yes or (no)

c. Life expectancy projection .....yes or (no)

If yes to any questions above in #17, submit a copy to the City of Detroit.

18. What specific body parts were impacted by the Injury/illness:

Neck, back, right hip and intracranial bleeding

19. That my Gender is: _____ Male ___✓___ Female

20. That the accident which gave rise to this Claim/Lawsuit occurred on:

5/23/12 (Date)

21. On 4-29-14 (Date), a Settlement or Judgement of my Claim/Lawsuit was agreed to/rendered for the total amount of

50,000 (Fifty Thousand) Dollars ($ 50,000).

22. On the date of the accident/event, did any household family member own an automobile with valid No Fault Insurance coverage.....yes or (no)

I, Lynne McDonald, HAVE READ THE ABOVE MEDICARE REPORTING AND INDEMNIFICATION AFFIDAVIT AND STATE THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT AND THAT IN THE EVENT THAT THE CITY OF DETROIT IS HELD LIABLE DUE TO ANY MISINFORMATION OR OMISSION OF INFORMATION BY AFFIANT IN THIS AFFIDAVIT, AFFIANT SHALL INDEMNIFY, HOLD HARMLESS AND REIMBURSE THE CITY OF DETROIT FOR ALL PAYMENTS, DAMAGES, MONIES, COSTS, ATTORNEY'S FEES, EXPENSES, MEDICARE LIENS, MEDICARE DEMANDS FOR REIMBURSEMENT, MEDICARE OFFSETS , MEDICARE FINES, MEDICARE PENALTIES AND ANY MEDICARE PAYMENTS INCURRED BY THE CITY OF DETROIT RESULTING FROM SAID OMISSION OR MISINFORMATION. FURTHER, I SHALL FULLY COOPERATE WITH THE CITY OF DETROIT IN ANY DISPUTE OR MATTERS RELATED TO THIS INCIDENT INVOLVING MEDICARE AND SHALL EXECUTE ALL DOCUMENTS REQUIRED OR REQUESTED BY THE CITY OF DETROIT, MEDICARE OR ITS AGENTS THAT MAY BE REQUIRED OR NECESSARY TO RESOLVE ANY SAID DISPUTE OR MATTER.

FURTHER AFFIANT SAITH NOT.

Carrie McDonald

SIGNATURE OF THE CLAIMANT/PLAINTIFF

STATE OF MICHIGAN)

)SS

COUNTY OF _____)

This Medicare Reporting and Indemnification Affidavit was acknowledged, subscribed and sworn to before me this 30 day of April, 2014, by CARRIE MCDONALD _____, who hereby declares under penalty of perjury under the laws of the State of Michigan that he or she is authorized in fact and law to execute this Medicare Reporting and Indemnification Affidavit.

Jennifer Picano

Notary Public, Wayne County,MI

My Commission Expires: December 11, 2015

Notary, Please ensure you use your notarial stamp or seal.

JENNIFER A. PICANO
NOTARY PUBLIC, STATE OF MI
COUNTY OF WAYNE
MY COMMISSION EXPIRES Dec 11, 2015
ACTING IN COUNTY OF
Oakland